Department of Budget and Finance

RELEASE DATE: October 6, 2023

REQUEST FOR PROPOSALS
RFP NO. 24-001

SEALED PROPOSALS
FOR
Medical Benefits
(including integrated prescription drug and chiropractic benefits) and
Pharmacy Benefit Management Services
(for self-insured prescription drug plans)

STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

WILL BE RECEIVED UP TO 12:00 NOON, HAWAII STANDARD TIME (HST) ON NOVEMBER 22, 2023

ELECTRONICALLY OR PHYSICALLY AT THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, CITY FINANCIAL TOWER, 201 MERCHANT STREET, SUITE 1700, HONOLULU, HAWAII 96813. DIRECT QUESTIONS RELATING TO THIS SOLICITATION TO DEREK M. MIZUNO VIA EMAIL AT EUTF.RFP@HAWAII.GOV.

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Derek M. Mizuno
Procurement Officer

Re: Request for Proposals – RFP No. 24-001, Medical Benefits and Pharmacy Benefit Management Services

Proposal Due Date: **November 22, 2023, 12:00 Noon, HST**

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is issuing this Request for Proposals (RFP), for its active employee and retiree medical benefits (including integrated prescription drug and chiropractic benefits) and pharmacy benefit management services for self-insured prescription drug plans.

This RFP has been divided into Sections which outline the items that are to be included in your submission (refer to Table of Contents). OFFEROR will be emailed census, network information, and claims information upon receipt of a completed and signed Attachment 2, *Intent to Bid Form* and signed Attachment 3, *Confidentiality Agreement* that are included in this RFP.

For Medical Benefits, OFFEROR may complete and submit proposals for multiple options by completing and signing the appropriate forms. Where there are multiple funding options requested for the same plan, an OFFEROR may submit requested options or only one of the options requested. The EUTF reserves the right to award multiple contracts as a result of this RFP. Separate contracts will be issued for Active Employee and Retiree Plans.

For Pharmacy Benefit Management Services for self-insured prescription drug plans, the EUTF intends to award contracts to the same OFFEROR for its commercial plan (active employees and non-Medicare retirees) and Medicare retirees. Separate contracts to the same OFFEROR will be awarded for Active Employee and Retiree Plans.

Each proposal must anticipate that the OFFEROR will provide those services outlined in this RFP without exception unless said exception is specifically identified in the proposal and identified in Attachment 5, *Exceptions*. Any deviations from the specifications should be clearly noted in Attachment 5 and may disqualify the proposal from consideration as not responsive. Exceptions to Attachment 6, *Performance Guarantees* will not be accepted by the EUTF.

Respond to all questions in this RFP. DO NOT ALTER THE QUESTIONS. Mis-numbered, incomplete, or unanswered questions may disqualify a proposal from consideration as not responsive.

Attachment 9, *Plan Summaries and Fee Proposal* included in the RFP shall be used for all cost and rate information. Information provided in any other format will not be accepted. Footnotes to the form(s) may be used to provide supplemental explanations, if necessary.

A network disruption analysis may be necessary in order to award a final contract with respect to coverage where a network of providers is utilized. In order to be considered, the OFFEROR must provide the appropriate data regarding your providers in the format that is requested.

All proposals must be submitted without any commissions included. No commissions, over-ride payments, finder's fees, or ancillary payments are to be made to any party on behalf of a contract issued to your company to provide these benefits. Violation of this requirement will invalidate your proposal or contract with the EUTF.

This RFP is the property of the EUTF. It is to be used by those companies, organizations, and individuals to whom copies have been sent solely for the purpose of preparing quotations for the plans described herein. Also, note Section 164.514(g) of HIPAA privacy rules states that the issuer or HMO may not use or disclose individually identifiable health information for any other purpose, except as may be required by law.

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ADMINISTRATIVE OVERVIEW

1.1 BACKGROUND

This Request for Proposals (RFP) is issued by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), an agency of the State of Hawaii (State). The EUTF was established by Act 88, 2001 Session Laws of Hawaii (SLH). Act 88 was partially codified as Chapter 87A, Hawaii Revised Statutes (HRS). Under HRS Chapter 87A, the EUTF is authorized to design, provide, and administer health and other benefit plans for State and county employees, retirees, and their dependents (aka "employee-beneficiaries" and "dependent-beneficiaries"). The benefit plans include medical, prescription drug, chiropractic, dental, vision, and life insurance. The EUTF currently provides benefit plans to over 118,000 subscribers which include employees and retirees. When dependents are included, the participant count is approximately 198,000. The EUTF's fiscal year is July 1 through June 30. Active employee plans are on a fiscal year term (July 1 to June 30) and retiree plans are on a calendar year term (January 1 to December 31).

The EUTF is administered by a board of ten Trustees (Board), who are appointed by the Governor. Five Trustees represent the employee-beneficiaries, one of whom represents retirees. These five Trustees are selected by the Governor from a list of candidates provided by exclusive employee representative organizations. The remaining five Trustees represent the public employers. The Board's responsibilities include determining the nature and scope of benefit plans, negotiating and entering into contracts to provide such plans, establishing eligibility and management policies, and overseeing all EUTF activities. The Board has adopted rules to administer the EUTF (see Exhibit C, *EUTF Administrative Rules*).

The EUTF's day-to-day operations are administered by an administrator appointed by the Board (Administrator). The Administrator is assisted in managing the EUTF by an Assistant Administrator, an Investment Office, a Benefits Office, a Member Services Branch Manager, a Financial Management Officer, and an Information Systems Chief. The Investment Office is responsible for all investment-related activities of the EUTF, and the Benefits Office is responsible for the benefit plan design, cost control through disease management and wellness programs, and auditing of claims. The day-to-day operations of the EUTF are organized under three branches: Member Services, Financial Services, and Information Systems. The Member Services Branch Manager oversees the Member Services Branch and is supported by employees assigned customer service duties such as answering phone calls and responding to emails from members and processing enrollment submissions for active employees and retirees. The Financial Management Officer is supported by accountants and account clerks who reconcile employee accounts, collect employer/employee contributions for health benefits, and process all payments. The Information Systems Chief is supported by information technology (IT) specialists who provide internal IT support services, including Health Insurance Portability and Accountability Act of 1996 (HIPAA) security responsibilities, and coordinate with the State Department of Accounting and General Services to provide additional support services.

In 2005, the Legislature enacted Act 245, partially codified as Chapter 87D, HRS. Act 245 temporarily permitted employee organizations to establish voluntary employees' beneficiary association (VEBA) trusts to provide health and other benefit plans to their members, including retirees. The stated purpose of Act 245 was to establish a pilot program to evaluate the costs and

benefits of VEBA trusts against the EUTF. One employee organization, the Hawaii State Teachers Association (HSTA), formed a VEBA trust effective March 1, 2006 and withdrew their members from the EUTF health and other benefit plans. Effective January 1, 2011, the VEBA trust was terminated, and all employees and retirees receive benefits through the EUTF. In December 2010, a State court ruled that HSTA VEBA members (active employees and retirees) were entitled to the same standard of coverage in benefits when they were transitioned to the EUTF on January 1, 2011. The enrollment of HSTA VEBA members into these new EUTF-created health and other benefit plans (HSTA VB) was done solely to comply with the Court's ruling and does not create any constitutional or contractual right to the benefits of these plans. If the ruling is overturned, stayed, or modified, the EUTF reserves the right to move HSTA VB members into regular EUTF plans.

The current Annual Report for the EUTF can be found online at **eutf.hawaii.gov**.

Active employees (also referred to as "actives") and retirees are currently offered medical plan options through HMSA, Kaiser, Humana, and HMA and prescription drug benefits through a self-insured plan administered by pharmacy benefit managers (PBM), Caremark PCS Health, LLC and SilverScript Insurance Company. Employers currently pay a portion of the premium cost for medical and prescription drug coverage for actives and their dependents and 100% of the premium for most retirees and their dependents. For actives, the employer's share is determined by the applicable collective bargaining agreement or through executive order. Any remaining balance is paid by the employee through payroll deduction. For retirees, benefit plan contribution amounts are established by Chapter 87A-33 to 87A-36, HRS.

A description of the current benefits is provided in Attachment 9, *Plan Summaries and Fee Proposal*, and Exhibit E, *Evidence of Coverage Documents*.

1.2 PURPOSE

The EUTF is soliciting proposals from qualified OFFERORS to provide medical benefits with integrated chiropractic (for actives and HSTA VB retirees) and prescription drug benefits and/or pharmacy benefit management services for self-insured prescription drug plans for the EUTF's active employees, non-Medicare retirees, Medicare retirees (which are provided prescription benefits through an EGWP Wrap Program), and eligible dependents.

Separate contracts will be issued for active and retiree plans. If a contract for pharmacy benefit management services for self-insured prescription drug plans is awarded, the EUTF intends to award such contracts for actives, non-Medicare retirees, and Medicare retirees to the same OFFEROR. EUTF seeks to maintain the current level of benefits and produce the most competitively priced plans with as little disruption to participants as possible. OFFERORS shall indemnify the EUTF insomuch that they will exactly duplicate the benefits currently offered by the EUTF if they assume the plans from a previous carrier and hold the participants in a no loss, no gain position.

1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

ACA	=	Patient Protection and Affordable Care Act
BAFO	=	Best and Final Offer
CPO	=	Chief Procurement Officer
DM/IHM	=	Disease Management/Integrated Health Management
EGWP	=	Employer Group Waiver Plan
EUTF	=	Hawaii Employer-Union Health Benefits Trust Fund
GC	=	General Conditions, issued by the State Department of the Attorney General
GET	=	General Excise Tax
HAR	=	Hawaii Administrative Rules
HRS	=	Hawaii Revised Statutes
IRA	=	Inflation Reduction Act of 2022
Offeror	=	Any individual, partnership, firm, corporation, joint venture, or representative or agent submitting an offer in response to this solicitation
PBM	=	Pharmacy Benefit Manager
PLO	=	Priority-listed offeror
Procurement Officer	=	The contracting officer for the State of Hawaii, EUTF
RFP	=	Request for Proposal
State	=	State of Hawaii, including its departments, agencies, and political subdivisions
Employee-Beneficiaries	=	An employee or retired employee of the state or counties that is eligible to enroll in the health plans offered by EUTF

1.4 CONTRACT PERIOD

The active employee plans are on a fiscal year term of July through June and the retiree plans are on a calendar year term. The term of any contracts resulting from this RFP, subject to approval by the State, shall be as follows:

A. Active Employee Plans:
   1. First Contract Period: July 1, 2025 – June 30, 2027
   2. Optional Second Contract Period: July 1, 2027 – June 30, 2028
   3. Optional Third Contract Period: July 1, 2028 – June 30, 2029

B. Retiree Plans (Non-Medicare and Medicare):
   1. First Contract Period: January 1, 2025 – December 31, 2026
   2. Optional Second Contract Period: January 1, 2027 – December 31, 2027
   3. Optional Third Contract Period: January 1, 2028 – December 31, 2028

All contract periods referenced throughout this RFP will be for these effective dates, including the proposal sheets. The term of the contract may be extended by the Board, at its sole discretion, to facilitate the transition to new contractors in progress at the end of the existing contract term. The

terms of such extension shall be the same as the then prevailing terms. The EUTF's ability to conduct audits shall survive the termination of the contract for a period equivalent to the term of the contract.

1.5 AUTHORITY

This RFP is issued under the provisions of Chapters 87A and 103D, HRS, and the implementing Administrative Rules. All prospective OFFERORS are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a proposal by any prospective OFFEROR shall constitute a representation of such knowledge on the part of such prospective OFFEROR.

1.6 CONTRACT ADMINISTRATOR

This RFP is issued by the EUTF. The individual listed below is the contract administrator and the Procurement Officer for this procurement.

Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1700
Honolulu, HI 96813

1.7 RFP SCHEDULE AND SIGNIFICANT DATES

Proposals must be received by November 22, 2023, 12:00 noon, Hawaii Standard Time (HST). Late proposals will be rejected and not considered. The table below represents the schedule that will be followed. All times indicated are based on HST. EUTF reserves the right to change any date(s) and times as deemed necessary and in the best interest of the State.

Release of Request for Proposals	**October 6, 2023**
Pre-proposal conference	**October 13, 2023**
Due date to submit Intent to Bid Form and Signed Confidentiality Agreement	**October 19, 2023**
Due date to submit written questions	**October 23, 2023**
State's response to written questions distributed	**November 3, 2023**
Proposals due (date/time)	**November 22, 2023 12:00 Noon, HST**
Priority-listed OFFEROR interviews (if required)	**Week of January 15, 2024**
Best and Final Offers due (if required)	**January 24, 2024**
Estimated date for notice of award	**February 14, 2024**

1.8 PRE-PROPOSAL CONFERENCE

The purpose of the pre-proposal conference is to provide OFFERORS with an opportunity to be briefed on this procurement and to ask any questions about this procurement. The pre-proposal conference is not mandatory; however, OFFERORS are encouraged to attend to gain a better understanding of the requirements of this RFP.

OFFERORS are advised that nothing discussed at the pre-proposal conference changes any part of this RFP. All changes and/or clarifications to this RFP shall be done in the form of an addendum.

Those interested may participate in the pre-proposal conference in person or via conference call. If your firm will be participating in the pre-proposal conference via conference call, please email eutf.rfp@hawaii.gov and provide the names, titles, and email addresses of those attending. The telephone number of the conference line is 877-477-0014. Passcode 630-378-9263#. The pre-proposal conference will be held as follows:

Date: October 13, 2023

Time: 9:00 a.m., HST

Location: EUTF Conference Room
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1700
Honolulu, Hawaii 96813

1.9 COMMUNICATIONS WITH THE EUTF

OFFERORS and potential OFFERORS (including agents of OFFERORS and potential OFFERORS) shall not contact any member of the EUTF Board, any member of the EUTF staff, or the EUTF's benefits consultant (Segal) except as specified in this RFP. An exception to this rule applies to companies who currently do business with the EUTF, provided that any contact made by any such company should be related to that business and should not relate to this RFP.

All questions regarding the RFP document shall be submitted in writing to the authorized contact person noted below in Section 1.10, *Issuing Office and Contact Person*. To facilitate a meaningful response, written questions shall reference the page, paragraph, and line or sentence to which the question relates. Such inquiries must contain identification of the OFFEROR, its email address, telephone and fax numbers, and the RFP number. Questions will be accepted until the due date to submit questions specified in Section 1.7, *RFP Schedule and Significant Dates*. No telephone calls will be accepted.

The EUTF will respond to questions through addenda/amendments by the date specified in Section 1.7, *RFP Schedule and Significant Dates*; responses to all questions will be available on the State Procurement Office's (SPO) website (http://www.spo.hawaii.gov) and the EUTF website (http://www.eutf.hawaii.gov/about-eutf/procurement/). The EUTF is not responsible for delays or non-receipt of such responses or any communications by the OFFERORS.

1.10 ISSUING OFFICE AND CONTACT PERSON

This RFP is issued by the EUTF. The individual listed below is the sole point of contact from the date this RFP is released until the award to the successful OFFEROR. Questions will be accepted only if submitted in writing and received on or before the day and time specified in Section 1.7, *RFP Schedule and Significant Dates.*

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813
Fax: (808) 586-2320
Email: eutf.rfp@hawaii.gov

A copy of this RFP can also be obtained from the EUTF website (http://eutf.hawaii.gov/about-eutf/procurement).

1.11 SUBMISSION OF PROPOSALS

OFFERORS must carefully examine this RFP, all amendments issued via addendum, all required contract forms, and other documents, laws and rules, as necessary, before submitting a proposal. The submission of a proposal shall be considered a warranty and representation that the OFFEROR has made a careful examination and understands the work and the requirements of this RFP.

Each qualified OFFEROR for medical benefits may submit only one proposal, although OFFERORS may propose to offer multiple plans within this RFP by completing and signing the appropriate forms. OFFERORS may submit proposals under all requested funding options, or only one for any plan. Incomplete or partial proposals will not be accepted.

Each qualified OFFEROR for pharmacy benefit management services for the self-insured prescription drug plans must include the active plans, non-Medicare retiree plans, and Medicare retiree EGWP plans with the supplemental (wrap). Incomplete or partial proposals will not be accepted.

OFFERORS have the option to submit their proposals under one of the two options below:

1. **Hard copies**:
   - One signed master proposal. The master proposal must be single-sided, unbound, and clearly marked, "Master."
   - Eight hard copies of the proposal. Each copy shall be marked, "Copy __ of 8." Copies may be bound and double-sided.
   - Two electronic copies (on two CDs or USB flash drives) of the master proposal and a redacted version of the proposal. Electronic copies of the proposals shall be submitted in Excel format for the completed proposal sheets and Word format for the completed questionnaire. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for submission to the public under any request compliant with the public

information disclosure laws of the State.

2. **Emailed and File-Sharing Electronic copies**:
   - Complete electronic versions of the master and redacted proposals, presented in logical sections (e.g., proposal, attachments, forms) shall be submitted in PDF format. Completed proposal sheets and the questionnaire shall be submitted in Excel format and Word format as instructed in the RFP. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for the submission to the public under any request compliant with the public information disclosure laws of the State.
   - The EUTF will accept emailed electronic files up to 35MB. If the OFFEROR's electronic files exceed 35MB, the EUTF will accept multiple emails and each email shall be numbered in the subject line or within the email message (e.g., "email #1" or "email 1 of __"). It is the OFFEROR's sole responsibility to ensure that a complete emailed proposal is electronically received by the EUTF at eutf.rfp@hawaii.gov no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.
   - For files larger than 35MB that cannot be emailed, OFFERORS also have the option of emailing their own file-sharing link to eutf.rfp@hawaii.gov. It is the OFFEROR's sole responsibility to ensure that emailed links to file-sharing services are received by the EUTF no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.

The OFFEROR's proposal, including the required submission types as noted above, must be received by EUTF no later than the closing date and time specified for the receipt of proposals as specified in Section 1.7, *RFP Schedule and Significant Dates*. Any proposal received after the closing date and time as specified in Section 1.7, *RFP Schedule and Significant Dates* will be rejected. No faxed or emailed proposals will be considered or accepted. Handwritten proposals will be rejected.

If selecting the hard copy option:
OFFERORS are encouraged to confirm their delivery agent's requirements for Hawaii. Proposals must be physically received by the EUTF via mail or hand delivery by **Wednesday, November 22, 2023, 12:00 noon, HST** and addressed to:

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

If the proposal is to be hand-delivered via courier (e.g., FedEx, UPS), the outside envelope shall be marked, "RFP No. 24-001, hand delivered, proposal due Wednesday, November 22, 2023, 12:00 noon, HST."

The outside cover of the package containing the proposal shall be marked:

State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
Proposal submitted in response to:
RFP No. 24-001, Medical Benefits and Pharmacy Benefit Management Services

In addition to the proposals submitted to EUTF, OFFEROR shall submit, as a courtesy, one electronic copy on CD or USB flash drive to SEGAL to be received no later than Wednesday, November 22, 2023, 12:00 noon, HST to the attention of:

Mr. Stephen Murphy
Segal
500 North Brand Boulevard, Suite 1400
Glendale, CA 91203
smurphy@segalco.com

1.12 RECEIPT, OPENING, AND RECORDING OF PROPOSALS

Proposals will be time stamped upon receipt and held in a secure place by the Procurement Officer until the established due date. Proposals will not be opened publicly, but in the presence of two State officials on or after the proposal submission deadline specified in Section 1.7, *RFP Schedule and Significant Dates* or as amended. Late proposals will not be accepted.

The register of proposals and the proposals of the OFFEROR(s) shall be open to public inspection upon posting of award pursuant to Section 103D-701, HRS.

1.13 MODIFICATION PRIOR TO DEADLINE OR WITHDRAWAL OF OFFERS

An OFFEROR may withdraw or modify a proposal prior to the final submission date. No withdrawals or re-submissions will be allowed after the final submission date. Proposals may be modified or withdrawn, prior to the deadline for submission of proposals, by the following:

- **Modifications** – The OFFEROR provides a written notice delivered by hand, email (eutf.rfp@hawaii.gov), mail, or fax that accompanies the actual modification.
- **Withdrawal** – The OFFEROR provides a written notice delivered by hand, mail or fax to the Procurement Officer; or a notice by email to eutf.rfp@hawaii.gov.

1.14 DISCUSSION AND PRESENTATIONS

Discussions may be conducted with PRIORITY-LISTED OFFERORS (PLOs) (i.e., OFFERORS who submit proposals determined to be reasonably susceptible of being selected for award). Such OFFERORS may be invited to make presentations to the Evaluation Committee to clarify their proposals, to promote understanding of the EUTF's requirements and the OFFEROR's proposal, and to facilitate arriving at a contract that will provide the best value to the State. Whether such discussions and presentations will be held will be at the discretion of the Evaluation Committee. An OFFEROR shall bear all responsibility for any and all costs related to making the presentations.

The EUTF reserves the right to conduct the presentations in person in Honolulu, virtually and/or via conference call.

1.15 BEST AND FINAL OFFER

If the EUTF determines a Best and Final Offer (BAFO) is necessary, it shall request one from the PLOs. BAFOs must be received by the EUTF no later than the date and time specified in Section 1.7, *RFP Schedule and Significant Dates,* or as may be amended by RFP addendum. If a BAFO is not requested by the EUTF, or if requested and not submitted by a PLO, the previous submittal will be construed as its BAFO. After BAFOs are received, final evaluations will be conducted for an award. All proposals become the property of the EUTF. The EUTF may destroy or return copies of proposals to non-winning OFFERORS.

1.16 PREPARATION OF PROPOSAL AND COSTS

The proposal shall be formatted in accordance with the requirements specified in this RFP.

Expenses for the development and submission of proposals and other responses to the RFP are the sole responsibility of the OFFEROR submitting the proposal or other responses regardless of whether any award results from this RFP. Travel and expenses are also the sole responsibility of the OFFEROR submitting a proposal or otherwise responding to this RFP.

1.17 DISQUALIFICATIONS OF PROPOSALS

The EUTF reserves the right to consider as acceptable only those proposals submitted in compliance with all requirements set forth or referenced in this RFP and which demonstrate an understanding of the scope of work. Any proposal offering any other set of terms and conditions, or terms and conditions contradictory to those included in this RFP, may be disqualified without further notice. All proposals must meet the minimum qualifications as established in this RFP for consideration.

Grounds for disqualification include:

- Proof of collusion among OFFERORS, in which case all proposals and OFFERORS involved in the collusive action will be rejected, and any participant to such collusion will be barred from future bidding until reinstated as a qualified OFFEROR.
- OFFEROR's lack of responsibility and cooperation as shown by past work or services rendered.
- OFFEROR being in arrears on existing contract(s) with the State or having defaulted on previous contract(s).
- Delivery of the proposal after the time specified in Section 1.7, *RFP Schedule and Significant Dates*.
- OFFEROR's failure to pay, or satisfactorily settle, all bills overdue for labor and materials on former contracts with the State at the time of issuance of the RFP.
- The proposal does not comply with applicable laws or contains provisions contrary to applicable law.
- The proposal is conditional, incomplete, or irregular in such a way as to make the proposal ambiguous as to its meaning.

- The proposal has provisions reserving the right to accept or reject award, or to enter into a contract pursuant to an award, or provisions contrary to those required in the RFP.
- OFFEROR's lack of sufficient experience to perform the work contemplated.
- OFFEROR's conflicts of interest or lack of independence in judgment.
- Handwritten proposals will be rejected.

1.18 RFP AMENDMENTS AND ADDENDUM

The EUTF reserves the right to amend this RFP at any time, prior to the closing date for BAFOs. All amendments will be issued by written addendum and will be posted on the following websites:

- SPO Hawaii Awards and Notices Data System (HANDS) (https://hands.ehawaii.gov/hands/welcome)
- EUTF (https://eutf.hawaii.gov/about-eutf/procurement/)

1.19 CANCELLATION OF REQUEST FOR PROPOSALS/REJECTIONS OF PROPOSALS

This RFP may be cancelled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State or for any other reason permitted by Chapter 103D, HRS, and its implementing Administrative Rules.

1.20 UNCERTAINTIES BEYOND THE CONTROL OF THE EUTF

The EUTF recognizes that circumstances beyond the control of the EUTF may arise that may significantly affect the ability of the Contractor to provide the services described in this RFP or as proposed by the Contractor. Accordingly, the EUTF reserves the right to modify the contract resulting from this RFP to address such circumstances within the scope of the RFP.

1.21 PROPOSAL BONDS; PERFORMANCE AND/OR PAYMENT BONDS

No proposal bond is required to be submitted with the proposal, and no performance or payment bond will be required for the contract awarded pursuant to this RFP.

1.22 EVALUATION OF PROPOSALS

An Evaluation Committee of at least three qualified State employees selected by the Procurement Officer shall evaluate proposals. The evaluation will be based solely on the evaluation criteria set out in Section III, *Proposal Evaluation* of this RFP.

Prior to holding any discussions with PLOs, a priority list shall be generated consisting of OFFERORS who are determined to be acceptable or potentially acceptable. However, an award may be made without such discussions.

If numerous acceptable and potentially acceptable proposals are submitted, the Evaluation Committee may limit the priority list to the highest ranked, responsive, and responsible OFFERORS. PLOs may be afforded the opportunity to submit BAFOs. If a BAFO is requested,

final evaluations will be conducted after BAFOs are received. If a BAFO is requested and is not submitted, the previous submittals will be construed as the BAFO.

1.23 AWARD OF CONTRACT

Award will be made to the responsible OFFEROR whose proposal is determined to be the most advantageous to the EUTF based on the evaluation criteria set forth in the RFP. If award is made, the successful OFFEROR will be required to enter into a formal written contract with the EUTF and shall be required to sign Exhibit F, *Business Associate Agreement* (BAA). The RFP, the OFFEROR's accepted proposal, the BAFO, and the executed contract comprise the contract. A copy of the *Contract Form and General Conditions* can be found at Exhibit D. The RFP and the successful proposal will be incorporated in the resulting contract by reference; to the extent that the RFP and successful proposal conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.

The notice of award resulting from this solicitation shall be posted on the SPO HANDS website (https://hands.ehawaii.gov/hands/welcome).

1.24 CONTRACT EXECUTION

The successful OFFEROR shall enter into a formal written contract in the form of Exhibit D, *Contract Form and General Conditions*. In submitting the proposal, the OFFEROR will be deemed to have agreed to each provision set forth in Exhibit D, *Contract Form and General Conditions* unless the OFFEROR specifically identifies the provision to which objection is made and submits alternative language as part of Attachment 5, *Exceptions*. The EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Exhibit D, *Contract Form and General Conditions*, this RFP and any amendments thereto. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF.

Upon selection and award of the contract(s), the EUTF will send the formal contract(s) and BAA to the successful OFFEROR(s) for signature. The contract and BAA shall be signed by the successful OFFEROR and returned with any required documents, within seven calendar days after receipt by the OFFEROR or within such time as the EUTF may allow. Failure to keep this deadline may result in a cancellation of the award and contract. EUTF reserves the right to cancel any contract, and request new proposals or negotiate with remaining OFFERORS, if the EUTF is not satisfied with the awarded Contractor's performance.

No work is to be undertaken by the Contractor prior to the effective date of the contract. The State is not liable for any work, contract costs, expenses, loss of profits, or any damages whatsoever incurred by the Contractor prior to the official start date. No contract shall be considered binding upon the EUTF until the contract has been fully and properly executed by all parties thereto.

If an option to extend the contract is mutually agreed upon, the Contractor shall be required to execute a supplement to the contract for the additional extension period.

1.25 REQUIREMENTS FOR DOING BUSINESS IN THE STATE OF HAWAII

OFFERORS are advised that in order to be awarded a contract under this solicitation, the OFFEROR will be required to be compliant with the following chapters of the HRS pursuant to HRS §103D-310(c) upon execution of a contract:

1. Chapter 237, General Excise Tax Law;
2. Chapter 383, Hawaii Employment Security Law;
3. Chapter 386, Worker's Compensation Law;
4. Chapter 392, Temporary Disability Insurance;
5. Chapter 393, Prepaid Health Care Act; and
6. §103D-310(c), Certificate of Good Standing (COGS) for entities doing business in the State.

If the OFFEROR is not compliant with the above HRS chapters at the time of contract execution, the OFFEROR may not receive the award. To demonstrate compliance, OFFERORS are encouraged to subscribe to Hawaii Compliance Express (HCE). OFFERORS who do not participate in HCE may submit paper compliance certificates to the EUTF.

The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the State Department of Taxation, Federal Internal Revenue Service, State Department of Labor and Industrial Relations, and State Department of Commerce and Consumer Affairs.

OFFERORS who are interested in registering in HCE should do so prior to submitting an offer at https://vendors.ehawaii.gov. The annual registration fee is currently $12.00 and the "Certificate of Vendor Compliance" is accepted for both contract execution and final payment.

1.26 PUBLIC EXAMINATION OF PROPOSALS

Except for confidential portions, the proposals shall be made available for public inspection upon posting of award pursuant to Section 103D-701, HRS.

If a person is denied access to a State procurement record, the person may appeal the denial to the State Office of Information Practices in accordance with Section 92F-42(12), HRS.

1.27 DEBRIEFING

Pursuant to Section 3-122-60, HAR, a non-selected OFFEROR may request a debriefing to understand the basis for award.

A written request for debriefing shall be made within three working days after the posting of the award of the contract. The Procurement Officer or designee shall hold the debriefing within seven working days to the extent practicable from the receipt date of written request.

Any protest by the requestor following a debriefing shall be filed within five working days after the date that the debriefing is completed, as specified in Section 103D-303(h), HRS.

1.28 PROTEST PROCEDURES

Pursuant to Section 103D-70, HRS and Section 3-126-3, HAR, an actual or prospective OFFEROR who is aggrieved in connection with the solicitation or award of a contract may submit a protest. Any protest shall be submitted in writing to the Procurement Officer at:

Mr. Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

A protest shall be submitted in writing within five working days after the aggrieved person knows or should have known of the facts giving rise thereto; provided that a protest based upon the content of the solicitation shall be submitted in writing prior to the date set for receipt of offers. Further provided that a protest of an award or proposed award shall be submitted within five working days after the posting of award or if requested, within five working days after the Procurement Officer's debriefing was completed.

The notice of award, if any, resulting from this solicitation shall be posted on the SPO HANDS website (https://hands.ehawaii.gov/hands/welcome).

1.29 SPECIAL CONDITIONS

The following Special Conditions will supplement Exhibit D, *Contract Form and General Conditions*:

1. Certificate of Authority/License. Prior to the effective date of the contract and during the entire term of the contract, the Contractor shall obtain and maintain all certificates of authority, licenses, and other approvals necessary to lawfully provide all benefit plans and/or services required under the contract. By accepting the award of contract, the Contractor certifies that: (a) it has all certificates, licenses, and approvals necessary to lawfully provide all benefit plans and/or services required under the contract; and (b) if applicable, that its benefit plans comply with all applicable federal, state, and county laws.

2. Compliance with EUTF Laws and Rules. The Contractor shall comply with: Chapter 87A, HRS, as amended from time to time; all rules, including, but not limited to, EUTF Administrative Rules, policies, standards, procedures, and directives adopted by the Board; and all policies, standards, procedures, and directives of the Administrator. The Contractor shall be bound by the Board's interpretation of Chapter 87A, HRS, and the EUTF's rules, policies, standards, procedures, and directives.

3. Records. Consistent with industry standards and practices, the Contractor shall maintain reasonable records pertaining to the Contractor's provision of all the benefit plans and/or services required under the contract and the Contractor's performance of the contract including,

but not limited to: (a) enrollment and eligibility records; (b) claims records; and (c) financial and accounting records showing all financial transactions pertaining to the Contractor's provision of benefit plans and/or services, the Contractor's performance under the contract, and all payments received or due to the Contractor under or relating to the contract. Unless otherwise agreed by the EUTF, all such records shall be kept and maintained in the State. Except as otherwise required by law, the Contractor shall maintain all records for at least three years from the date of final payment under the contract. Records which relate to an appeal, litigation, or settlement of claims arising out of the contract shall be retained by the Contractor for at least three years after the subject appeal, litigation, or claim has been disposed of or otherwise resolved.

4. Accounting. Except as otherwise required by law, the Contractor's accounting procedures and practices shall conform to generally accepted accounting principles consistently applied and all fees and costs applicable to the contract shall be readily ascertainable from the Contractor's records.

5. Inspections and Audits. At all times that it is required to maintain records under the contract, the Contractor shall make such records available at its local office for inspection or audit by authorized representatives of the EUTF, the State Auditor, and/or the State Comptroller. Such inspections and audits may include but is not limited to: (a) claims audits; (b) audits relating to the performance standards and guarantees required under the contract; (c) audits relating to the Contractor's performance of the contract and compliance with the contract's terms and conditions; and (d) the Contractor's claimed fees, costs, and expenses. To the extent that the Contractor proposes to use or uses any subcontractors to fulfill its obligations under the contract, those subcontractors must agree to abide by the record keeping, accounting, and audit requirements of the contract.

6. Liquidated Damages. In the event of any breach of the contract by the Contractor, liquidated damages shall be assessed against the Contractor in the sum of $5,000.00 per calendar day until the breach is remedied by the Contractor.

7. Insurance. Prior to the contract start date, the Contractor shall procure, at its sole expense, and maintain insurance coverage acceptable to the State in full force and effect throughout the term of the contract. The Contractor shall provide proof of insurance for the following minimum insurance coverage(s) and limit(s) in order to be awarded a contract. The type of insurance is listed as follows:

    a. An insurance policy or policies that cover claims resulting from the Contractor's negligent or willful acts, errors or omissions, breach of contract, breach of fiduciary or other duty, violation of statute or other law, in providing services under the contract. The policy or policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board. Initially, the insurance policy must have limits of liability in the amount of at least $10,000,000, per occurrence and in the aggregate. The insurance policy shall be endorsed to provide that it is primary insurance and not contributing to or in excess over any coverage that the EUTF, Board or State of Hawaii may carry.

b. A fidelity bond, commercial crime policy, or other equivalent insurance that provides insurance coverage or similar protection to the EUTF against forgery, theft, robbery, fraud, dishonest and criminal acts committed by any of the Contractor's employees that causes the EUTF to sustain monetary loss. The limits of such bond or policy shall be $5,000,000 per occurrence and in the aggregate.

c. Commercial general liability insurance coverage against claims for bodily injury and property damage arising out of all operations, activities or contractual liability by the Contractor, its employees and subcontractors during the term of the Contract. This insurance shall include the following coverage and limits specified or required by any applicable law: bodily injury and property damage coverage with a minimum of $3,000,000 per occurrence; personal and advertising injury of $1,000,000 per occurrence. The commercial general liability policy shall be written on an occurrence basis and the policy shall provide legal defense costs and expenses in addition to the limits of liability stated above. The Contractor shall be responsible for payment of any deductible applicable to this policy.

d. Automobile liability insurance covering owned, non-owned, leased, and hired vehicles with a minimum of $1,000,000 for bodily injury for each person, $1,000,000 for bodily injury for each accident, and $1,000,000 for property damage for each accident or $3,000,000 combined single limit.

e. Appropriate levels of per occurrence insurance coverage for workers' compensation and any other insurance coverage required by Federal or State law.

f. Cyber liability insurance with limits not less than $25,000,000 per occurrence/claim, $25,000,000 aggregate. Coverage shall be sufficiently broad in response to the duties and obligations as is undertaken by the scope of work within this contract and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall also provide coverage for breach response costs and regulatory fines and penalties and credit monitoring expenses.

g. Any and all other insurance that is required by applicable law and that is reasonably necessary in order for the Contractor to perform the work and services required under the contract. The insurance policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board, as measured by what a reasonably prudent trustee would require of a Contractor in similar circumstances.

   If the Contractor maintains broader coverage and/or higher limits than the minimums shown above, the State requires and shall be entitled to the broader coverage and/or higher limits maintained by the Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the State.

   The adequacy of the coverage afforded by the Contractor's insurance shall be subject to review by the Board, from time to time, and if it appears that a reasonably prudent trustee,

operating a trust fund similar to that operated by the Board, would require an increase in the limits of liability of such insurance, the Contractor shall, to that extent, take all necessary actions to increase such limits.

All the required insurance shall be carried with insurance carriers that have a general policyholder's rating of not less than A and a financial rating of no less than VII in the most current A.M. Best's Insurance Reports. If the A.M. Best's ratings are changed or discontinued, the parties shall agree to an equivalent method of rating insurance companies.

Throughout the entire term of the contract, the EUTF, the Board and its trustees shall be named as additional insureds on all the required insurance policies except for professional liability/errors and omissions and worker's compensation policies. Prior to the commencement of the contract, the Contractor shall provide the EUTF with certificates of insurance showing that it is carrying all the insurance required hereunder. At or prior to the expiration of all insurance policies required hereunder, the Contractor shall provide the EUTF with certificates of insurance showing the renewal or replacement of such insurance policies. All policies of insurance shall provide that the EUTF will be given 30 days' notice in writing in advance of any cancellation, lapse or reduction in the amount of insurance.

Each insurance policy required by this contract, including a subcontractor's policy, shall contain the following clauses:

(1) "This insurance shall not be canceled, limited in scope of coverage, or non-renewed until after 30 days' written notice has been given to the Hawaii Employer-Union Health Benefits Trust Fund, 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813."
(2) "The State of Hawaii, the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), the EUTF Board of Trustees, and trustees of the EUTF Board are added as additional insureds with respect to operations performed for the State of Hawaii and the EUTF."
(3) "It is agreed that any insurance maintained by the State of Hawaii and/or the EUTF will apply in excess of, and not contribute with, insurance provided by this policy."

The minimum insurance required shall be in full compliance with the Hawaii Insurance Code throughout the entire term of the contract, including supplemental agreements.

Upon Contractor's execution of the contract, the Contractor agrees to deposit with the EUTF, certificate(s) of insurance necessary to satisfy the EUTF that the insurance provisions of this contract have been complied with and to keep such insurance in effect during the entire term of this contract, including those of its subcontractor(s), where appropriate.

Upon request by the State, the Contractor shall be responsible for furnishing a copy of the policy or policies.

Failure of the Contractor to provide and keep in force such insurance shall be regarded as material default under this contract, entitling the EUTF to exercise any or all of the remedies provided in this contract for a default of the Contractor.

The procuring of such required insurance shall not be construed to limit the Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, the Contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract.

8. Transition Procedures. At no cost to the EUTF, the Contractor shall comply with the following provisions upon receipt of a notice of termination or upon the expiration of the contract:

   a. As directed by the EUTF, the Contractor shall terminate or assign to the EUTF or its designee any outstanding orders or contracts that relate to the Contractor's performance under the contract.

   b. The Contractor shall transfer title and deliver to the EUTF or its designee, any and all completed or partially completed goods, materials, reports, information, data or other work product of the Contractor that were made under the contract or as part of the Contractor's performance of the contract.

   c. As directed by the EUTF, the Contractor shall destroy and/or deliver to the EUTF or its designee all confidential or proprietary documents, information, and data that the Contractor has received under the contract and all copies thereof.

   d. The Contractor shall provide to the EUTF or its designee all records, documents, information, and data reasonably necessary to allow the EUTF or its designee to continue to provide and/or administer, without interruption, all health and other benefit plans to EUTF beneficiaries, and to comply with all federal, state, and other legal requirements to which the EUTF is subject. Such records, documents, information, and data shall include, but not be limited to, eligibility information and data, claims experience or history data, and administrative records. This will include, but not be limited to:

      - All claim files for the entire contract period
      - Medical Necessity Review Files
      - Prior Authorization files
      - Medical deductible and Maximum Out of Pocket (MOOP) balances
      - Formulary exception approvals
      - Pharmacy Quantity Limit information by participants and exceptions
      - Pharmacy True Out of Pocket (TrOOP) balances

   e. As directed by the EUTF, the Contractor shall handle retroactive enrollments for persons who should have been enrolled prior to the effective date of the termination or expiration, the run-off of all claims incurred prior to the effective date of the termination or expiration,

and any other requirements of the contract that apply to the period of time prior to the effective date of the termination or expiration.

f. The Contractor shall provide the EUTF with a final accounting of claims, premiums, reserves, and retention covering the last unreported period of time up to and including the effective date of termination or expiration, a final monthly operation report, a final plan performance and paid accounting report, and a final quarterly report on financial operations and performance standards.

g. With respect to fully insured proposals, the OFFEROR's premium rates must include the cost of all run-out claims and claims administration after the termination of the contract for a period of no less than 12 months, with a final reconciliation at this 12-month period. With respect to self-insured proposals, the OFFEROR must include in its fees the cost of payment of all run-out claims after the termination of the contract for a period of no less than 12 months, with a final reconciliation of the self-funded accounts at this 12-month period. No additional fees will be paid and all costs of the run-out claim administration must be included in the monthly fees during the contract period.

PROPOSAL INSTRUCTIONS

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS REQUEST FOR PROPOSAL

2.1 CONTENT OF PROPOSAL

The OFFEROR shall adhere to all instructions listed in Section 1.11, *Submission of Proposals*, and prepare a written proposal that will fully describe the qualifications and availability of the OFFEROR to provide the services requested and the compensation the OFFEROR proposes in response to this RFP. The proposal shall include, without limitation, the following:

- Cover letter
- Offer Form, OF-1 (Attachment 1)
- Confidential Information (Attachment 4)
- Exceptions (Attachment 5)
- Proposal Documents (Section VI)
    - Schedule 1: Offeror Information Sheet (Attachment 7)
    - Schedule 2: Key Personnel
    - Schedule 3: Financial Statements
- Medical Proposal Documents
    - Schedule 4: Medical Questionnaire (Attachment 8)
    - Schedule 5: Plan Summaries and Fee Proposal (Attachment 9)
    - Schedule 6: Provider Network
- PBM Proposal Documents
    - Schedule 7: PBM Questionnaire (Attachment 10)
    - Schedule 8: PBM Proposal (Attachment 11)
    - Schedule 9: Retail Pharmacy Network
    - Schedule 10: Formulary
    - Schedule 11: Drug Utilization Review and Trend Report
- Any additional attachments/marketing information including but not limited to documents related to an audit policy, fraud detection program, and HIPAA compliance plan

2.2 COVER LETTER

The RFP response must include a cover letter addressed to the Administrator. The letter, which will be considered an integral part of the proposal, must contain the following:

- Contact Information. The cover letter shall include the OFFEROR's name, address, telephone/fax numbers, and email address.
- Terms and Conditions of RFP. A statement that the OFFEROR fully understands and will comply with all terms and conditions contained in the RFP. The OFFEROR must include written acknowledgment of receipt of any and all amendments or addenda made to this RFP.
- Legal Entity. A statement indicating that the OFFEROR is an individual, a partnership, a limited liability company, a corporation or other legal entity and the jurisdiction where the OFFEROR is organized.

- Authorized Signature. The cover letter shall be signed by an individual or individuals authorized to legally bind the OFFEROR. If the OFFEROR is a corporation, evidence in the form of a certified copy of a corporate resolution or certified copy of articles of incorporation or bylaws shall be submitted showing the individual's authority to bind the corporation. If the OFFEROR is a partnership, the proposal shall be signed by all the partners, or evidence in the form of a certified copy of the partnership agreement shall be submitted showing the individuals' authority to bind the partnership. Similar evidence shall be submitted for an individual signing the proposal letter on behalf of any kind of entity.
- Current Licenses and Registration. A statement that the OFFEROR maintains or will obtain the current licenses necessary to provide the services required. In addition, an OFFEROR must provide evidence that the OFFEROR is registered to do business in the State prior to commencement of the work. True and accurate copies of the OFFEROR's license(s) and certificates must be provided. See Section 1.25, *Requirements for Doing Business in the State of Hawaii*.
- Subcontracting of Services. A statement by the OFFEROR indicating that the work described in the RFP will not be subcontracted. However, if subcontractors will be used, append a statement to the cover letter from each subcontractor, signed by an individual authorized to legally bind the subcontractor stating: 1) the general scope of work to be performed by the subcontractor, and 2) the subcontractor's willingness to perform the indicated tasks. The extent to which the work will be subcontracted and the qualifications of any subcontractor will be considered in evaluating the OFFEROR's ability to perform the service referred to in the RFP.
- Non-Discrimination. A statement that the OFFEROR does not discriminate in employment or business practices with regard to race, color, religion, age (except as provided by law), sex, sexual orientation, marital status, political affiliation, national origin, disability, or any other characteristic protected by federal, state or local laws.
- EUTF Rights Regarding Contractor's Recommendations. A statement that the OFFEROR understands that the EUTF reserves the right to disapprove the Contractor's recommendations without penalty when they conflict with the policy or fiscal interests of the EUTF, as determined by the Board.
- Terms and Conditions of Contract. Affirm that the provisions of the sample contract in Exhibit D, *Contract Form and General Conditions* are acceptable or state any proposed modifications in Attachment 5, *Exceptions*. The EUTF reserves the right to decline or classify as "unresponsive" any substantive changes, modifications, or revisions to the provisions of the sample contract. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF.

2.3 OFFER FORM, OF-1

Include a signed, Attachment 1, *Offer Form OF-1* with the exact legal name, as registered with the State Department of Commerce and Consumer Affairs, if applicable, and address of OFFEROR's firm and the name, mailing address, telephone number, and fax number of the person the State should contact regarding the OFFEROR's proposal. The OFFEROR's authorized signature (original or electronic) on the *Offer Form, OF-1* shall be required before an award, if any, can be made. The submission of the proposal shall indicate the OFFEROR's intent to be bound.

2.4 CONFIDENTIAL AND PROPRIETARY INFORMATION

The OFFEROR shall list in Attachment 4, *Confidential Information*, those portions of the proposal that contain trade secrets or other proprietary data/information that the OFFEROR wishes to remain confidential. The OFFEROR shall follow the instructions under Section 1.11, *Submission of Proposals*, for submitting a redacted copy of its proposal. The OFFEROR must also include on Attachment 4 a detailed explanation as to why this information is considered confidential, with respect to the requirements of Chapter 92F, HRS. Any request for public inspection is subject to the requirements of Chapter 92F, HRS. The entire proposal CANNOT be considered confidential. The fee proposal CANNOT be considered confidential. With the indication of sections that are deemed proprietary and confidential, the OFFEROR must include a written explanation of the nature and rationale for considering the information as confidential.

2.5 AWARD OR REJECTION

Award will be made to the OFFEROR whose proposal is deemed to be in the best interest of the EUTF. The EUTF reserves the right to reject any or all proposals.

2.6 NO COMMISSIONS

No commissions will be paid and none are to be included in any proposal and no designation of "Broker of Record" will be issued to any OFFEROR in order for the OFFEROR to procure a quotation from an insurance company. No override payments, volume bonuses or other indirect payments to agents or producers are allowed.

2.7 INTENT TO BID FORM AND CONFIDENTIALITY AGREEMENT

All OFFERORS must submit a completed signed Attachment 2, *Intent to Bid Form* and signed Attachment 3, *Confidentiality Agreement* in order to receive the claims data and employees' census. These documents are required for the OFFEROR to receive the census and claims data but are not required to be eligible to submit a proposal.

2.8 ORAL EXPLANATIONS

The EUTF will not be bound by oral explanations or instructions given during the competitive process or after the award of the contract.

2.9 TIME FOR ACCEPTANCE

The OFFEROR agrees to be bound by its proposal for a contract effective date as stipulated in Section 1.4, *Contract Period*.

2.10 EXCEPTIONS

Any exceptions to terms, conditions, or other requirements in any part of these specifications (including Section IV, *Scope of Work* and Section V, *PBM Scope of Work*) must be listed in Attachment 5, *Exceptions*. The OFFEROR shall reference the RFP section where the exception is taken, a description of the exception taken, and the proposed alternative, if any. Otherwise, it will

be considered that all items offered are in strict compliance with the specifications. Amendments or clarifications shall not affect the remainder of the proposal, but only the portion so amended or clarified. In instances where there is a material difference between a proposal and this RFP, the RFP terms will be binding unless specifically accepted as an exception stipulated in the contract. The EUTF reserves the right to accept or reject any request for exceptions. Exceptions to Attachment 6, *Performance Guarantees,* will not be accepted by the EUTF.

2.11 SUBMISSION OF A SIGNED PROPOSAL

Submission of a signed proposal shall be construed as the OFFEROR's strict adherence to this RFP, unless otherwise noted in writing in the required Attachment 5, *Exceptions*. Failure to meet any of these conditions may result in disqualification of the proposal. This RFP and the OFFEROR's proposal, including all subsequent documents provided during this RFP process, will become part of the contract between the parties.

2.12 CLAIMS REPRICING

As a condition of the final award of contract and determination of net cost to the EUTF, all PLOs must provide re-priced claim information (as provided by Segal to the PLOs) in the requested format, including the information requested in the claim re-pricing worksheet.

2.13 ASSUMPTIONS OR UNDERWRITING PROVISIONS

It is required that all proposals **exclude** any language referring to the right of the OFFEROR to change rates due to changes in expected versus actual enrollment for any period of the term of the contract. Failure to comply with this requirement will be a significant adverse consideration in the proposal evaluation.

2.14 EUTF ADMINISTRATIVE RULES

The OFFEROR must comply with Exhibit C, *EUTF Administrative Rules*, as amended from time to time. Any proposed modifications to the specified eligibility rules are unacceptable.

2.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

All OFFEROR systems and services must be in compliance with the HIPAA Electronic Data Exchange (EDI), Privacy, and Security rules and regulations on the appropriate dates established by the U.S. Department of Health & Human Services. The successful OFFEROR will be required to sign Exhibit F, *Business Associate Agreement*.

2.16 PLAN DESIGN AND FUNDING ARRANGEMENTS

The current plans and funding arrangements are provided in Section 4.9, *Plan Offerings*.

OFFERORS are required to match the EUTF's current plan of benefits for any of the options for which you are submitting a proposal. Benefit plans are summarized in Attachment 9, *Plan*

Summaries and Fee Proposal. In cases where a discrepancy may exist, the OFFEROR must agree to administer benefits on a "no loss, no gain" adjudication of the benefits when compared to the current contractors and insurance companies including reasonable and customary schedules, administrative interpretation of the benefits, covered services and prior authorizations. Contractor shall be responsible for fully complying with federal and state laws for fully insured plans, unless the Contractor's position differs from the EUTF and its legal counsel. This RFP requests bids on any of the following two options: (1) the current fully insured/refunding arrangement where surpluses are returned to the EUTF, but deficits may not be collected or carried forward to future contract years/terms and (2) self-insured administrative services only basis.

If the OFFEROR is submitting a fully insured or self-insured bid for pharmacy benefits, the OFFEROR will be responsible to administer pharmacy benefits for retirees where a Medicare dependent of a non-Medicare retiree is covered under the Medicare EGWP Wrap plan and a non-Medicare dependent of a Medicare retiree is covered under the non-Medicare retiree plan (orphaned dependents). A fully insured pharmacy benefit must comply with all the requirements contained in the RFP for self-insured pharmacy benefits.

If the OFFEROR is submitting a fully insured bid for Medicare Advantage benefits, the OFFEROR will be responsible to administer Medicare Advantage benefits for retirees where a Medicare dependent of a non-Medicare retiree is covered under the Medicare Advantage plan and a non-Medicare dependent of a Medicare retiree is covered under the non-Medicare retiree plan (orphaned dependents).

PROPOSAL EVALUATION

3.1 INTRODUCTION

The EUTF seeks the highest quality organization to provide medical benefits and pharmacy benefit management services. Throughout the selection process, the EUTF reserves the right, in its sole discretion:

a. To not award the contract to the lowest cost OFFEROR, or
b. To not award the contract at all.

3.2 EVALUATION PROCESS

An Evaluation Committee selected by the Procurement Officer will review and evaluate all proposals submitted by the deadline specified in the RFP. The evaluation process will be conducted in up to six phases:

Phase 1 – Evaluation of Mandatory Requirements
Phase 2 – Establishment of PLOs
Phase 3 – Discussions with PLOs (Optional)
Phase 4 – Request for BAFOs (Optional)
Phase 5 – Final Evaluation of Proposals (Optional)
Phase 6 – Award

1. Evaluation of Mandatory Requirements. The evaluation of the mandatory requirements shall be on a "pass/no pass" basis. The purpose of this phase is to determine whether an OFFEROR's proposal is sufficiently responsive to the RFP to permit a complete evaluation. Each proposal will be reviewed for responsiveness. Failure to meet the mandatory requirements ("no pass") will be grounds for deeming the proposal non-responsive to the RFP and rejection of the proposal. Only those proposals meeting the following requirements ("pass") of Phase 1 will be considered in Phase 2.

    - Adhere to all proposal submission guidelines.
    - Follow proposal submission timeline (refer to Section 1.7, *RFP Schedule and Significant Dates*).
    - The proposal must include proposed rates for the initial contract period and all extension contract periods.
    - All proposed rates (including administrative fees) must be guaranteed for the term of the contract, including the proposed extensions. There shall be no contingencies on the proposed rates.
    - There shall be no time limitations on the validity of the proposal.
    - Submission of evidence of financial stability. If the OFFEROR is not able to submit evidence with the proposal, the OFFEROR must agree to submit evidence if selected as a PLO.
    - The OFFEROR must agree to be bound, in order of precedence, by 1) the contract between the State and the Contractor, 2) the RFP including all attachments and addenda, and 3) the Contractor's proposal.

2. Establishment of PLOs. All OFFERORS who pass Phase 1, Evaluation of Mandatory Requirements, shall be classified as "acceptable" or "potentially acceptable." The Evaluation Committee will evaluate all proposals and establish a priority list of OFFERORS who received the best preliminary evaluations. The order, priority, and points to be applied to each evaluation criteria are as listed in Section 3.3, *Evaluation Criteria and Points*.

3. Discussions with PLOs (Optional). In this phase, the Evaluation Committee may conduct interviews with the PLOs as listed in the timeline provided in Section 1.7, *RFP Schedule and Significant Dates*. This phase is optional and may not be included in the evaluation.

4. Request for BAFOs (Optional). In this phase, the PLOs may be asked to submit a BAFO for the services that are being proposed. This phase is optional and may not be included in the evaluation.

5. Final Evaluation of Proposals (Optional). In this phase, the Evaluation Committee will conduct final evaluations in accordance with the criteria listed in Section 3.3, *Evaluation Criteria and Points*. This phase is optional and may not be included in the evaluation.

6. Award. The EUTF Board will make the final selection.

3.3 EVALUATION CRITERIA AND POINTS

The evaluation criteria listed below will be used to evaluate and rank each OFFEROR's proposal.

Criteria	**Points** Medical Benefits	**Points** PBM Services
Fees/rates/network discounts	30	30
Network/formulary disruption	25	30
Agreement to perform services requested in RFP (including Section 1.29, *Special Conditions*)	25	25
Experience offering services to similar sized entities and references including prior engagements with the EUTF and the State	10	10
Medical management programs, wellness programs and total health management approach	10	NA
Agreement to establish a local (in-state) mail order fulfillment center to be fully operational prior to January 1, 2025 (as required in Section 5.7, *Mail Order Program*)	NA	5
Total	100	100

1. Fees/rates/network discounts.

   Medical Benefits: For the fully insured options, the cost will be calculated as the rates times the annual enrollment for plan of benefits for which a proposal sheet is submitted using the enrollment that is contained in Section 4.9, *Plan Offerings* of this RFP. For the self-insured options, the cost will be calculated as the combination of the monthly administrative fees, times the annual enrollment for each plan plus the value of the network discounts which is determined from repricing of the claims submitted to the PLOs in the BAFO phase of the RFP process. The evaluation will exclude all ACA fees and tax.

   PBM Services: The net cost of benefits and administration will be determined from the pricing and discount and rebate guarantees (based on the EUTF's current formulary) included in the OFFEROR's proposal applied to the historical claims that were supplied to the OFFERORS as claims data. Only guaranteed pricing, discounts, rebates, and administrative expenses will be used in the evaluation. Estimated discounts and rebates will not be considered in the evaluation.

2. Network/formulary disruption. Network disruption will be evaluated and measured based upon the providers, facilities, and other sources of care and services used by the participants in the plans for which a proposal is being submitted, as measured from the experience of the plan over the past twelve months. Special consideration will be made of the OFFEROR's ability to provide a network of providers for all islands on which EUTF plan participants reside. The census files submitted to OFFERORS include residence zip code locations. Network disruption will be analyzed as follows:

   Medical Benefits: The total score for this category will be determined by adding the points for each of the following:

   - Network Disruption Analysis. The percentage of the plan enrolled population that will not be required to change providers from those that had been used over the past twelve months per the network data provided in the RFP (multiplied by 12.5 points).
   - Geo Access. The result of the Geo Access analysis (as described in Section 6.6, *Medical Provider Network*) that is submitted with the proposal on a per island basis with equal weighting allocated to each island (multiplied by 12.5 points divided by 6).

   PBM Services: The total score for this category will be determined by adding the points for each of the following:

   - Network Disruption Analysis. The percentage of retail pharmacy dispensing facilities in the OFFEROR's network that have been used over the past twelve months per the claims data provided in the RFP (multiplied by 12.5 points).
   - Geo Access. An evaluation of the number of network facilities (as described in Section 6.9, *Retail Pharmacy Network*) that are available to participants within the State on a per island basis (multiplied by 12.5 points divided by 6).
   - Formulary Disruption Analysis. Bidders to provide counts and percentage of members/drugs moving from a lower tier to higher tier and members/drugs moving to excluded status. Bidders to provide percentage of drugs on the submitted formulary with prior authorization, percentage of drugs on the submitted formulary with step

therapy, and percentage of drugs on the submitted formulary with quantity limits (total 5.0 points).

3. Agreement to perform services requested in RFP (including Section 1.29, *Special Conditions*). This category will be evaluated based upon the responses contained in the proposal with respect to the OFFEROR's agreement to perform all of the services required in a manner and to the specifications outlined in this RFP. The OFFEROR's thorough explanation of how it will complete the required tasks outlined in the RFP will be evaluated based upon its understanding of the tasks, the demonstrated ability to perform the tasks and agreement to dedicate the necessary resources to perform the tasks. Exceptions listed in Attachment 5 will also be considered.

4. Experience offering services to similar sized entities and references including prior engagements with the EUTF and the State. The analysis of this category will be the result of reviewing the list of referred entities for which the OFFEROR is providing identical or very similar services including any prior contracts of the OFFEROR or its affiliates or precedent corporation with the EUTF or the State and prior litigation with the EUTF and/or the State, and references that are comparable in the number of enrolled participants, benefit plan comparability, complexity of administration and a similar form of administrative entity (Trustee Board with dedicated Administrative Organization) and geographic dispersion of participant population. Each supplied reference will be interviewed for an evaluation of the performance of the OFFEROR with respect to the contracted services performed including any work performed for EUTF in a prior contract.

5. Medical management programs, wellness programs, and total health management approach (medical benefits only). This category will be evaluated upon the demonstration in the OFFEROR's response of an integrated, well developed program of managing the total health and disease management of the participants, as well as an integrated wellness program that is directed at improving the health outcomes of the participants and overall health status of the participant population. This includes the agreement to exchange meaningful data on the health status of EUTF participants with the EUTF and its designated vendors and consultants and to provide quarterly reports to the EUTF on the outcomes of the efforts of the proposers programs in a timely and complete manner as described by the EUTF.

6. Agreement to establish a local (in-state) mail order fulfillment center to be fully operational prior to January 1, 2025 (PBM services only). This category will be awarded on a pass/fail basis and the points in this category will only be awarded to those OFFERORS that have established or agree to establish a fully operational mail order prescription fulfillment center located in the state. The mail order center must be capable of fulfilling the projected number of prescriptions submitted by participants based upon previous experience of the EUTF. Should the mail order facility not be fully operational by January 1, 2025, the full amount of liquidated damages ($5,000 per calendar day) will be assessed in accordance with Section 1.29, *Special Conditions*, *6. Liquidated Damages*. A physical examination of the facility may be required by the Evaluation Committee or its designee prior to the award of the points in this category.

SCOPE OF WORK

4.1 BACKGROUND

A description of the current benefits is provided in Attachment 9, *Plan Summaries and Fee Proposal*, and Exhibit E, *Evidence of Coverage Documents*. Effective January 1, 2011, the EUTF began providing separate plans to all members of the HSTA who were formerly enrolled in the HSTA VEBA plans ("HSTA VB").

4.2 BASIC SERVICES

The EUTF is issuing this RFP for its active and retiree medical benefits (with integrated chiropractic and prescription drug benefits) and pharmacy benefit management services for self-insured prescription drug plans. The Contractor shall provide the benefits and services that are: (1) required under this RFP; (2) proposed by the Contractor and accepted by the EUTF; and (3) otherwise required under the contract between the Contractor and the EUTF.

All OFFERORS are required, at a minimum, to provide the current level of benefits, including prescription drug benefits. A description of the current benefits is provided in Attachment 9, *Plan Summaries and Fee Proposal*, and Exhibit E, *Evidence of Coverage Documents*. No PBM Services are required for the Supplemental, Closed Panel HMO, or Part-Time/Temporary Employee plans.

4.3 CUSTOMER SERVICES

During the entire term of the contract and fully operational by Open Enrollment Period for Retirees in October 2024, the Contractor must maintain the following located in the State:

1. Call Center. The Contractor shall have a call center in the State with knowledgeable staff available to answer inquiries from EUTF members regarding: (1) the benefits provided by the Contractor; (2) the Contractor's benefit plans, forms, and procedures; (3) enrollment status; (4) premium costs; (5) claims and claim procedures; (6) COBRA; and (7) other matters pertaining to the benefit plans provided under the contract. The call center must record and retain all call recordings, transcripts, and notes for a minimum of one year from the date of the call.

   Medical Benefits: 100% of the medical plan calls between 7:00 AM to 7:00 PM, HST Monday through Friday, excluding State observed holidays, and 9:00 AM to 1:00 PM, HST on Saturday, shall be answered by the local call center. The medical plan must also have a toll-free line for EUTF members that is open and available during those hours, at no additional cost.

   PBM Services: The prescription drug plan must have a toll-free line for EUTF members that is open and available 24 hours a day, seven days a week, at no additional cost. Calls outside of 7:00 AM to 7:00 PM, HST Monday through Friday, excluding State observed holidays, and 9:00 AM to 1:00 PM, HST on Saturday, may be answered at a call center not in the State but in the U.S. and one whose employees have been trained on the EUTF benefits (including the retail, mail order, and specialty programs).

2. Walk-in Center (medical benefits only). A walk-in customer service center located in Honolulu to service plan participants. The walk-in customer service center shall be open during EUTF business hours, 7:45 AM to 4:30 PM, HST, Monday through Friday, except State observed holidays.

3. Staffing and Equipment. The Contractor shall have personnel, systems, and equipment at the service offices that is reasonably sufficient to provide all the customer services proposed by the Contractor and required under the contract.

4.4 MEMBER COMMUNICATION

1. ID Cards. At its own expense (including postage), the Contractor shall provide ID cards as specified in Attachment 6, *Performance Guarantees* and in accordance with the No Surprises Act.

2. Benefit Material. At its own expense, the Contractor shall draft, print, and regularly update written information that describes its benefit plan(s) in detail and a list of its providers. Upon request, the written information and list shall be provided to the EUTF's employee-beneficiaries and dependent-beneficiaries.

3. Website. At its own expense, the Contractor shall host its own EUTF-dedicated member portal website. The website shall be updated at least twice a year prior to open enrollment.

PBM Services: The PBM Contractor shall notify members 30 calendar days in advance of when a member's utilized drug is excluded or moved to a higher cost tier. If the latter, the notification must include at least one formulary alternative. This includes a change in the member's cost share due to a service warranty.

The PBM Contractor shall obtain the EUTF's approval for all member communication materials before distribution to members. The PBM Contractor shall not automatically enroll the EUTF in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the EUTF. The EUTF reserves the right to review, edit, or customize any communication from the PBM Contractor to its membership, unless restricted by federal law.

4.5 KEY PERSONNEL

The EUTF account team shall be located in Hawaii and available during EUTF business hours to answer questions from or hold discussions with the Board or its designee in person, the Administrator, EUTF staff, EUTF's consultants, and the Attorney General's office with respect to the Contractor's benefit plans, Contractor's performance of the contract, or any matter pertaining to the EUTF. The Contractor must provide responses to EUTF staff phone calls and emails promptly. Sufficient backup personnel must be in place to ensure that this requirement is met on a consistent basis. The Contractor shall notify the EUTF at least 10 days in advance of any change in the authorized representatives and are subject to the terms of Attachment 6, *Performance Guarantees*.

4.6 MEETINGS

Among the authorized representatives, Contractor shall designate a contract liaison officer who shall be responsible to the EUTF for Contractor's performance of the contract. The contract liaison officer shall attend all meetings as requested by the Board, its subcommittees, or its designee, the Administrator, or EUTF's consultants.

1. Trustee Meetings. The Contractor shall attend the Board's regular, special, and Benefits Committee meetings as may be required by the Board or the Administrator. The Contractor shall attend in person if requested or via teleconference.

2. Meetings with EUTF staff. The Contractor shall attend monthly meetings with EUTF staff and its consultants to provide updates on pending matters such as the status of upcoming Board presentations, audits, contracts, service issues, etc. The Contractor shall attend in person if requested or via teleconference.

4.7 ELIGIBILITY

Eligibility of EUTF employee-beneficiaries and dependent-beneficiaries for enrollment in and coverage by the Contractor's benefit plans shall be determined under HRS chapter 87A and Exhibit C, *EUTF Administrative Rules*. The Contractor shall be bound by the EUTF's determinations regarding eligibility of EUTF employee-beneficiaries and dependent-beneficiaries.

The Contractor shall accept enrollment, life event changes, and cancellation dates as stated in EUTF transmissions, reports, or files. The Contractor shall accept enrollment eligibility dates for Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage in accordance with federal law as determined by the Administrator and the employers' departmental personnel offices.

4.8 ENROLLMENT

1. Processing Enrollments, Cancellations and Terminations. Weekly, the EUTF will provide a HIPAA compliant electronic data transmission that shows new enrollments, cancellations, terminations, and other changes applicable to the Contractor's benefit plan(s). Subject to the following, the Contractor shall process such enrollments, cancellations, terminations, and changes in a timely manner. The Contractor shall agree to accept all of the enrollment and enrollment change information provided by the EUTF benefits administration system, in 834 file format, using the codes that are provided in this file, to maintain all eligibility and process transactions. The Contractor shall process the transaction file noting member enrollment changes (additions, deletions, and changes of address, employment, etc.) and the full file showing all members that are eligible for benefits. A sample of the full file and transaction file in 834 file format is contained in Exhibit G. The Contractor agrees to incur all expenses of any modifications that are necessary to its systems in order to process the information provided by the EUTF. The EUTF will not make any modifications to its current system or file content or structure to accommodate the Contractor. All changes necessary to comply with the requirements of this section shall be made prior to the commencement of this contract.

However, the EUTF may agree to make changes to its 834 file format if time permits and if paid by the Contractor.

Between the dates that the EUTF makes the electronic data transmissions, the EUTF may request the Contractor to perform new enrollments or other changes to enrollment, including accepting and processing manual paper and/or electronic forms which may be submitted in order for an enrollment change to be expedited. The Contractor shall accept such requests and perform the requested enrollments or other changes in a timely manner. New enrollments and other changes shall be performed no later than 48 hours after receipt of the EUTF's request.

2. Open Enrollment. Each year, the EUTF holds at least one open enrollment period for active employees and one open enrollment period for retired employees. Historically, the active open enrollment period is in April and the retiree open enrollment period is in October. The EUTF may also hold special open enrollment periods during other times of the year.

   Prior to open enrollment periods, EUTF staff solicits benefit plan information from all Contractors that explains and updates their benefit plan coverages, exclusions, limitations, service locations, network providers (including mail order facilities and HMO health centers), descriptions of new clinical programs, etc. EUTF staff then coordinates the distribution of benefit plan booklets, news bulletins, notices, enrollment applications, and other forms related to the open enrollment. The Contractor shall provide all information requested by the deadlines determined by EUTF staff.

   During the open enrollment period, the EUTF holds various informational sessions for employee-beneficiaries and dependent-beneficiaries throughout the State on most islands. At its own expense, the Contractor shall attend and provide staff any written informational materials for such informational sessions.

   The Contractor shall provide any other assistance as may be requested by EUTF staff in connection with any open enrollment period.

3. Other Enrollment Assistance. From time to time, the EUTF may hold training sessions for its staff and/or other government personnel involved in EUTF operations (e.g., the public employers' departmental personnel officers). In addition, the EUTF holds informational meetings at various places around the State for its employee-beneficiaries and dependent-beneficiaries (e.g., periodic pre-retirement and retirement informational meetings for employees, "benefits fairs" and/or informational meetings for employees facing a reduction in force). Upon EUTF's request and at its own expense, the Contractor shall attend and provide staff any written informational materials for these training sessions, benefits fairs and informational meetings.

   Upon request and at no additional cost to the EUTF, the Contractor shall provide information to the EUTF necessary to update its eligibility and enrollment files (e.g., current addresses of employee-beneficiaries).

The Contractor and its staff shall cooperate with and provide timely information and assistance to EUTF employee-beneficiaries and dependent-beneficiaries who are applying for State and county employee benefits including disability retirement.

4.9 PLAN OFFERINGS

The following shows the medical and prescription drug plans currently offered by the EUTF and the enrollment count as of September 2023:

Plan Description	Plan	Total Subscribers	Total Members
EUTF Actives			
Fully insured (with risk sharing) medical with integrated chiropractic and self-insured prescription drug administered by CVS Caremark	HMSA 90/10 PPO	2,517	3,863
	HMSA 80/20 PPO	10,984	19,151
	HMSA 75/25 PPO	19,433	39,256
	HMSA HMO	714	1,099
Fully insured medical with integrated chiropractic and prescription drug	Kaiser Comprehensive HMO	4,044	7,000
	Kaiser Standard HMO	9,054	17,348
Self-insured supplemental medical and prescription drug	HMA Supplemental	588	1,619
HSTA VB Actives			
Fully insured (with risk sharing) medical with integrated chiropractic and self-insured prescription drug administered by CVS Caremark	HMSA 90/10 PPO	804	1,580
	HMSA 80/20 PPO	1,733	4,370
Fully insured medical with integrated chiropractic and prescription drug	Kaiser Comprehensive HMO	630	1,447
EUTF Non-Medicare Retirees			
Fully insured (with risk sharing) medical	HMSA 90/10 PPO	5,397	10,190
Fully insured medical with integrated prescription drug	Kaiser Comprehensive HMO	1,091	1,940
Self-insured prescription drug administered by CVS Caremark	EUTF Prescription Drug	6,408	11,639
EUTF Medicare Retirees			
Fully insured (with risk sharing) medical	HMSA 90/10 PPO	34,510	48,074
Fully insured medical	Humana MA LPPO	56	65
Fully insured medical with integrated prescription drug	Kaiser Permanente Senior Advantage HMO	7,198	9,680
Self-insured prescription drug administered by SilverScript	EUTF Prescription Drug	32,535	45,089

Plan Description	Plan	Total Subscribers	Total Members
HSTA VB Non-Medicare Retirees			
Fully insured (with risk sharing) medical with integrated chiropractic and self-insured prescription drug administered by CVS Caremark	HMSA 90/10 PPO	6	7
Fully insured medical with integrated chiropractic and prescription drug	Kaiser Comprehensive HMO	4	5
Self-insured prescription drug administered by CVS Caremark	HSTA VB Prescription Drug	11	12
HSTA VB Medicare Retirees			
Fully insured (with risk sharing) medical with integrated chiropractic and self-insured prescription drug administered by SilverScript	HMSA 90/10 PPO	2,009	2,938
Fully insured medical with integrated chiropractic and prescription drug	Kaiser Permanente Senior Advantage HMO	217	295
Self-insured prescription drug administered by SilverScript	HSTA VB Prescription Drug	1,997	2,923

Additional Requested Plans:

1) **Plan for Part-Time and Temporary Employees:** EUTF is requesting proposals for temporary and part-time employees and their dependent children up to age 26. Please provide a rate on Proposal Sheets 4 and 9. OFFERORS proposing on 1) Proposal Sheet 3 must complete Proposal Sheet 4 and 2) Proposal Sheet 7 must complete Proposal Sheet 8.

2) **Fully Insured Chiropractic Integrated with the Medical Plan:** EUTF is requesting proposals for a fully insured chiropractic plan integrated into the Medical Plans for all active employees and HSTA VB retirees. OFFERORS should also provide pricing for fully insured chiropractic benefits for EUTF retirees which will not be evaluated.

3) **Fully Insured Prescription Drug Plan Integrated with the Medical Plan and/or Self-Insured stand-alone prescription drug plan.** EUTF is requesting proposals for active employee prescription drug plans, non-Medicare prescription drug plans, and Medicare prescription drug plans (EGWP with supplemental wrap or Medicare Part D plan integrated with a Medicare Advantage plan).

For actives and retirees, dental benefits are provided through Hawaii Dental Service (HDS), vision benefits through Vision Service Plan (VSP), and life insurance benefits through Securian Financial.

4.10 ACTIVE PART-TIME AND TEMPORARY EMPLOYEE PLAN ADMINISTRATION

The Employers participating in the EUTF, in order to comply with the requirements under the ACA (including essential health benefit requirements), offer temporary and part-time employees the opportunity to enroll themselves and their dependent children to age 26, in a low-cost plan offered by the EUTF at the time of initial employment and during the annual open enrollment period. The premium will be entirely paid by the employee. The EUTF requires the services described below for the active part-time and temporary employee plans from the Contractor who is awarded the 75/25 plan and the Closed Panel Standard HMO plan, respectively. Separate rates will be developed for this group, and the experience for this group may not be applied against the experience of the EUTF plans. The rates for this group should be community-rated and guaranteed for each of the contract periods of the active plan. The EUTF will not bear any of the expense of offering these plans. The premiums charged must be self-supporting and the plan agreement must be structured as a group plan offered by the employer so as to prevent the employers from exposure to the penalties under ACA, Section 4980(H)(a). **Note**: OFFEROR is requested to offer a proposal without including the spouse in the proposal.

The Contractor shall:

- Conduct all open enrollment sessions
- Receive enrollment election forms from the Employer
- Process enrollment and maintain database of enrolled employees and dependents
- Distribute all ID cards and enrollment material to the enrollee
- Provide full customer service with respect to questions from the participants with regard to eligibility, billing, claims, and benefits
- Report enrollment to the individual employers and EUTF if required
- Send premium billing to participant and collect all premiums monthly
- Comply with all continuation requirements under COBRA and administer same for this group
- Ensure plans comply with federal and state laws
- Send cancellation notices upon non-payment of premium
- Process any change of enrollment requests during the plan year due to the permitted addition or deletion of dependents as required under all applicable laws, including but not limited to HIPAA
- Separately account for the claim experience of this group in reporting to the EUTF
- Process terminations when reported by the individual employers
- Provide all federal and State required communication and information to the participants
- Provide written notification to the EUTF of any annual rate changes 120 days prior to the commencement of the EUTF annual open enrollment for Active Employee Plans subject to the rate maximum included in the response to this RFP.
- Include in the rates, all taxes, fees and all ACA fees as required under ACA
- Perform all reporting to the federal and State agencies as required under ACA, and
- Issue annual insurance certificates as required under ACA

The Employer may terminate offering the optional part-time temporary plan should provisions of the ACA which require it be modified or repealed.

4.11 COBRA ADMINISTRATION

The Contractor is required to administer all aspects of compliance under COBRA, including eligibility, election of coverage, billing and collection of premiums, termination, and annual and termination notification.

4.12 WORKSITE WELLNESS ACTIVITIES

The EUTF supports planning and implementation of worksite wellness activities for its employers throughout the year. Such activities may include, but not limited to, wellness fairs, health promotion classes, biometric screenings, monthly webinars, and worksite challenges. Upon request and at no additional cost to the EUTF or its employers the Contractor shall accommodate employer activities including, but not limited to, providing staff and resources including travel on Oahu and to the neighbor islands, biometric screening services with online scheduling and outcomes reporting, content experts or instructors, benefit and program materials and handouts, interactive displays, and participation incentives including door prizes, logo items, healthy meals or snacks. Other activities may be requested, for development, to align with improvement plans and strategic planning documents.

4.13 COORDINATION OF BENEFITS

The Contractor shall provide all services necessary to coordinate benefits between its medical and prescription drug plans (or any self-insured plans it administers on behalf of the EUTF) and other non-EUTF medical and prescription drug plans (including Medicare) of the EUTF's employee-beneficiaries and dependent-beneficiaries without any additional claim form submissions by the beneficiaries. It shall be the responsibility of the Contractor to pursue 100% compliance with disclosure of coordination of benefits ("COB") information from participants. Compliance will be in accordance with the National Association of Insurance Commissioner Guidelines.

PBM Services: The PBM Contractor shall ensure claims adjudication and coordination of benefits with non-EUTF plans (including Medicare) at point of sale to ensure members receive benefits seamlessly. The PBM Contractor shall credit the EUTF the cost difference for any claims in which the EUTF prescription drug plan was considered primary but should have been considered secondary (e.g., workers' compensation claim).

4.14 REPORTS AND ACCOUNTINGS

All reports that the Contractor is required to give to the EUTF under the contract shall be in form and substance satisfactory to the EUTF. The EUTF may require changes to the form or content of the reports. The Contractor shall meet report deadlines and format requirements as indicated in an agreed upon report calendar which will be included as part of the Contract. If the report due date falls on a weekend or State holiday, the due date will be the next business day.

1. Operation Reports. The Contractor shall provide monthly operation reports to the EUTF. The monthly operation reports shall be in memo format and due 10 days after the end of the month that is the subject of the report. The monthly operation reports shall include, but not be limited to, the following: (1) operational issues pertaining to EUTF members participating in the

Contractor's plans such as member mailings or network changes; (2) issues raised by or with the Contractor and correspondence to or referred to the Contractor; (3) publications or press releases relating to the Contractor's plans that may be of interest to EUTF members; (4) community activities relating to the Contractor that may be of interest to EUTF members; (5) any legal actions or proceedings involving EUTF members; and (6) any complaints by EUTF members to the Contractor or the Insurance Division relating to the Contractor's plans or the Contractor's administration of EUTF self-insured plans.

PBM Services: In addition to the information noted above, the PBM monthly operation reports shall include notification of any participating pharmacy closures and prescription drug recall notices.

2. Financial Reports. The Contractor shall provide monthly reports on financial operations electronically in Excel format. The monthly financial reports shall be due 30 days after the end of the month that is the subject of the report. The Contractor shall also provide quarterly financial and enrollment reports by bargaining unit.

   PBM Services: In addition to the monthly financial report noted above, the PBM Contractor shall provide a financial reconciliation report within 90 days after the end of each contract year, and the report will include the contractual and actual discounts and dispensing fees for each component (e.g., retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, and specialty drugs at the PBM's Specialty Pharmacy) without the need for formal audit.

3. Performance Guarantee Reports. The Contractor shall provide quarterly reports on performance guarantees electronically. The quarterly reports shall be due within 30 days after the end of the quarter that is the subject of the report.

4. Utilization Reports. The Contractor shall provide a semi-annual utilization report within 120 days after the end of the 2nd and 4th quarter. The report data shall be broken out by actives, non-Medicare retirees, and Medicare retirees and compared to the Contractor's book of business utilization and cost data.

   PBM Services: The PBM Contractor shall provide a quarterly utilization report within 60 days after each quarter. The report data (including # of prescriptions submitted by single source brand, multi-source brand and generic drugs, average AWP, ingredient cost per prescription, dispensing fee, average days' supply, and detail of cost and utilization trends by top drug products) shall be broken out by actives, non-Medicare retirees, and Medicare retirees and compared to the PBM Contractor's book of business utilization and cost data.

5. HEDIS and Burden of Disease Reports (medical benefits only). The Contractor shall provide an annual HEDIS and burden of disease report. The report shall include but not be limited to EUTF disease prevalence and preventive measures compared to NCQA HEDIS benchmarks and the Contractor's book of business for similar public entities.

6. Disease Management/Integrated Health Management (DM/IHM) and Wellness Reports (medical benefits only). The Contractor shall provide an annual DM/IHM and wellness report within 30 days after the end of the calendar year. The report shall include but not be limited to annual program planning for subsequent years, annual return on investment for disease management and wellness programs, and a detailed line-item report on how DM/IHM fees are used.

7. Mail Order Cost Comparison (PBM services only). The PBM Contractor shall provide a date-sensitive quarterly comparison report showing unit costs charged to the EUTF at a GCN-level and reimbursement, on a dollar-for-dollar basis, of all instances where mail order unit costs exceed retail unit costs.

8. Claim Reports. Upon request, the Contractor shall provide a report containing information (drug name, dosage, ingredient cost, day supply, dispensing fee, member cost share/coinsurance/COB, submitted charge, allowable charge, and paid amount) on all claims received and/or processed by the Contractor during a specified period of time. Such a report shall be provided electronically in Excel format.

   PBM Services: Upon request, the PBM Contractor shall provide a claims data file that corresponds to the invoices at no additional cost.

9. Special Reports. Upon reasonable advance notice, the EUTF may request special reports on matters pertaining to the Contractor's benefit plans and/or the Contractor's performance of the contract, including but not limited to the following:

High-cost claimant report	Prior authorization and other clinical program reporting (including PA denial rates by therapeutic drug class)
Drug utilization review activity and savings report by type of edit	Pharmacy Network cost and utilization reporting (includes number of patients, scripts, dollar volume)
Therapeutic interchange report detailing success rates and cost impacts of PBM initiated interchanges % if % or drug utilization review	Transcripts of customer service call recordings and detailed call notes upon request (indicate how soon the report will be available after the call has occurred)
Formulary savings and rebate by drug report	High-cost prescriber report

10. EGWP Reports. The PBM Contractor shall provide all CMS required report filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis, including but not limited to: CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements, network Geo Access, member coordination of benefits, and all CMS-required member communications.

4.15 CONFIDENTIAL INFORMATION

The Contractor shall protect all information, records, and data collected in connection with this contract from unauthorized disclosures. The EUTF and Contractor shall determine if and when any other party may have authorized access to such information.

The Contractor shall guard the confidentiality of participant information. Access to participant information shall be limited by the Contractor to persons or agencies that require the information in order to perform their duties in accordance with the contract. Any other party shall be granted access to confidential information only after compliance with the requirements of all federal, state, and county laws pertaining to such access (e.g., HIPAA).

The Contractor is required to know and understand the confidentiality laws that pertain to its benefit plan and its performance under the contract. This includes knowledge and understanding of laws specific to certain groups (i.e., HRS chapter 577A relating to minor females and pregnancy and family planning services, HRS §325-101 relating to persons with HIV/AIDS, HRS §334-5 relating to persons receiving mental health services, and 42 CFR Part 2 relating to persons receiving substance abuse services).

Nothing in this section shall prohibit the Contractor from disclosing information to the EUTF or its designee.

4.16 ELECTRONIC DATA TRANSMISSIONS

The Contractor shall have and maintain HIPAA compliant hardware, software, and systems that can retrieve or receive electronic data transmissions from the EUTF regarding enrollments, changes to enrollments, premiums, and other matters related to the contract. The Contractor shall, at its own expense, develop all interfaces and system modifications to receive the data provided by the EUTF in the EUTF's format, layout and content which is HIPAA 834 compliant. The EUTF will not make modifications to its systems in order to comply with any system requirements of the Contractor. All changes must be made to the Contractor's system and at the Contractor's expense prior to commencement of the contract. However, the EUTF may agree to make changes to its 834 file format if time permits and if paid by the Contractor. A copy of the 834 file and content are included as Exhibit G of this RFP.

The Contractor shall accept the EUTF's HIPAA-compliant, weekly electronic data transmissions as the official membership eligibility/enrollment records, subject to adjustments as authorized by the EUTF.

The Medical Contractor shall provide claim information to the PBM Contractor (and vice versa) on a monthly or quarterly basis throughout the term of the contract in order to develop a coordinated and integrated health management process and to assist the EUTF with the overall management of healthcare expenses, including pharmaceutical expenses. The Medical Contractor shall also provide out of pocket expense information with the PBM Contractor (and vice versa) on a daily basis in order to comply with the mandated maximum out of pocket expense regulations contained in the ACA. This requirement does not apply to plans that provide an integrated medical and

prescription drug benefit. **Note**: The PBM Contractor shall remove retiree drug only data from the claims file that is shared with the medical carrier at no additional cost.

The Contractor(s) shall provide medical, pharmacy and/or health management program claim utilization and cost data to the EUTF upon request for analysis and its Benefit Consultant (Segal) on a monthly basis for its data warehouse (SHAPE). The cost of preparing the claims data in a format required by the EUTF shall be included in the Contractor's proposal.

The Contractor shall also submit claims data to the All Payor Claims Database (APCD) established by the State pursuant to Act 139, SLH 2016 which amends HRS 323D-18.5. The Contractor agrees to cooperate with the State to effectuate all data transfers from the Contractor to State or its designee.

1. APCD Data General Requirements.
    a. The State's APCD collects and uses data for many reasons such as establishing baseline information; monitoring and analyzing health care costs; assessing population health; measuring utilization of services; identifying health disparities; informing consumers of cost and quality of healthcare; supporting planning and evaluation of healthcare operations and care; improving coordination of care; enabling oversight of health insurance premium medical loss ratios; fraud, waste, and abuse studies; audits, investigations, identifications of improper payments, and other program integrity activities; federal and state reporting; rate setting and risk adjustment; policy analysis, executive and legislative decision-making; assessment of utilization patterns and access to care; and other research studies.
    b. The Contractor shall ensure data received from providers and other subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in a standardized format. The Contractor shall make all collected data available to EUTF.
    c. The Contractor shall maintain appropriate systems and mechanisms to obtain all necessary data from its health care providers and subcontractors to ensure its ability to comply with all APCD data reporting requirements. The failure of a healthcare provider or subcontractor to provide the Contractor with necessary data shall not excuse the Contractor's non-compliance with this requirement.
    d. The Contractor shall submit data to the APCD in accordance with the specifications in the HHDC APCD Data Submission Guide (currently available at https://phidc.ssri.hawaii.edu/wp-content/uploads/2018/06/SHPDA-HHDC-APCD-Data-Submission-Guide-v1.0.pdf). This includes, but is not limited to: eligibility, enrollment, and disenrollment data; claims and encounters; and provider data.
    e. The Contractor shall submit APCD data for all services rendered to members under this Contract (except those enrolled under the Part-Time Temporary Employee plans), including claims and encounters where the Contractor determined no liability exists, and whether the encounter was processed as paid or denied, along with any adjustments, replacements, backouts, or voids of claims or encounter records previously submitted.
    f. The Contractor shall submit APCD data even if the Contractor did not make any payment for a claim or encounter, including claims and encounters for services to members provided under subcontract, capitation, or special arrangement with another facility or program. Encounters related to value-added services or additional benefits offered by the Contractor

shall be submitted and appropriately flagged to enable them to be distinguished and parsed as necessary.

g. The Contractor shall submit claims and encounter data for all services provided under this Contract to members who also have Medicare or other TPL coverage, if a claim has been submitted to the Contractor. Claims and encounter data for services paid by Medicare or other TPL shall be flagged to indicate source of payment.
h. The Contractor shall submit data to the APCD in accordance with the requirements and specifications defined by the State and included in the HHDC APCD Data Submission Guide, published by SHPDA and incorporated by reference into this Contract. SHPDA may periodically update the HHDC APCD Data Submission Guide with notice to the Contractor. The Contractor shall, upon receipt of such notice from SHPDA, provide notice of changes to subcontractors.
i. All data shall be submitted via a designated electronic mechanism such as a secure file transfer protocol (SFTP) service as specified in the HHDC APCD Data Submission Guide. The data will be used to create a database that may be used for purposes described previously. The APCD may edit records to ensure consistency and readability.
j. All data shall be submitted to SHPDA or SHPDA's designee as specified in the HHDC APCD Submission Guide. The Contractor shall submit one hundred (100) percent of claims and encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters.
k. The Contractor shall continue reporting data once per month beyond the term of the Contract as processing and reporting of the data is likely to continue due to lags in time in filing source documents by subcontractors and providers.
l. The Contractor and its subcontractors shall retain all data for a period of no less than ten (10) years. Provisions shall be made by the Contractor to maintain permanent history by service date for those services identified as once-in-a-lifetime, including examples such as hysterectomy.

2. <u>APCD Data Submission Content and Format</u>.
   a. The APCD data submitted shall be certified for completion and accuracy and submitted by the Contractor concurrently with each upload.
   b. The Contractor and its subcontractors shall exclusively utilize the submission formats defined in the HHDC APCD Data Submission Guide for the electronic communication of all APCD data submitted. Additionally, the Contractor and its subcontractors shall follow the instructions and guidelines set forth in the most current versions of ICD-10-CM, Healthcare Common Procedure Coding System, Current Procedural Terminology, and other standard nomenclature and classification systems. When submitting APCD data, the Contractor shall adhere to all requirements specified in the HHDC APCD Data Submission Guide.
   c. Submitted data shall pass all APCD system edits and audits. Submitted data shall not be a duplicate of a previously submitted and accepted data unless submitted as an adjustment, replacement, backout, or void. The Contractor shall make changes or corrections to data and any systems, processes, or data transmission formats as needed to comply with the APCD's data quality standards.
   d. The Contractor shall make an adjustment to data within thirty (30) days from when the Contractor discovers that data is missing, incorrect, no longer valid, or some element of

the encounter not identified as part of the original encounter needs to be changed, except as noted otherwise.

e. If the APCD discovers errors or a conflict with a previously adjudicated encounter claim, the Contractor shall be required to adjust or void the encounter claim within thirty (30) days of notification, or if circumstances exist that prevent the Contractor from meeting this timeframe, a specified data shall be approved by the APCD.

f. The Contractor shall uniquely identify claims and encounters paid under FFS, capitated, bundled, or other arrangements for its network providers. For capitated arrangements, the Contractor shall report each service, including those that resulted in a zero payment, when applicable. For bundled payments, the Contractor shall submit details on each service provided; each service rendered during an encounter shall be parsed into service lines to enable accurate computation of service utilization in these settings. Capitation detail records shall be required for each provider and member combination for each time period in which a capitation payment is made to the provider. For claims and encounters not uniquely tied to a payment, such as encounters for services rendered under a capitation arrangement, the Contractor shall submit a FFS equivalent valued amount for the encounter.

3. Accuracy, Completeness, and Timeliness of APCD Data Submissions.

a. The Contractor shall submit accurate, complete, and timely data to the APCD in accordance with the requirements and specifications defined by the APCD and included in the HHDC APCD Data Submission Guide, published by SHPDA and incorporated by reference into this Contract.

b. The APCD shall conduct data validation to ensure accuracy, timeliness, and completeness for the populations served by the Contractor under this Contract.

c. The Contractor will conduct reconciliation against their Contractor data to ensure accuracy, timeliness, and completeness using definitions, protocols, and timelines specified in the HHDC APCD Data Submission Guide.

d. The APCD will determine the overall extent of the data quality of the data submitted and accepted and determine whether any issues are within the data quality tolerance thresholds of successfully accepted data.

e. For any data quality issues identified, the Contractor shall have the opportunity to correct errors and resubmit the APCD data and additionally provide an explanation for any remaining discrepancies during the error resolution process. The APCD will review any explanations provided, conduct its reviews, and make a final determination on whether the Contractor has exceeded the data quality thresholds for the interval that cannot be justified for reasons other than data quality and completeness.

f. Except under circumstances where the APCD determines that the Contractor has exceeded the data quality thresholds in a manner that is justifiably unrelated to the Contractor, the APCD shall use the submitted and accepted data.

g. The APCD reserves the right to change its data validation process at any time, with notice to the Contractor.

h. The APCD will provide the Contractor with error reports via the SFTP file server after each submission. See the HHDC APCD Data Submission Guide for additional detail on data timelines and error reports.

4.17 PAYMENT TO CONTRACTOR

Fully Insured Plans: Payment to the Contractor will be done in arrears, after the month is completed. Such payments shall be made by the 15th day of the following month. If the 15th day of the month falls on a weekend or holiday, the payment will be made on the next business day.

Self-Insured Plans: The Contractor shall invoice the EUTF twice monthly for claims and once monthly for administrative services based on EUTF enrollment counts. The EUTF shall pay the Contractor all invoiced amounts within 20 days after the EUTF receives an invoice from the Contractor, on the 15th and 30th of each month. The Contractor may request a deposit in an amount equal to two billing cycles based on the average of the last three months of billing history.

If the EUTF disputes all or a portion of any invoice, the EUTF will pay the undisputed amount timely and notify the Contractor, in writing, of the specific reason and amount of any dispute before the due date of the invoice. The Contractor and EUTF shall work together, in good faith, to resolve any dispute. Upon resolution, the EUTF or the Contractor shall remit the amount owed to the other party, if any, within ten (10) business days as the parties agree based on the resolution.

All Plans: For purposes of calculating the amount of premiums or fees due the Contractor, the number of employee-beneficiaries enrolled in Contractor's plans shall be determined by the EUTF as of a given date of the month, to be selected by the EUTF. Retroactive additions and terminations shall be accounted for in future payments.

Contractor shall accept the monthly summary enrollment reports provided by the EUTF as the basis for the amount of premiums due the Contractor under the contract. Contractor shall notify the EUTF in writing within 90 calendar days after the end of the report month of any transaction or premium computation discrepancy or other problem in the monthly summary report. The Contractor shall provide specific information that is necessary to resolve any noted discrepancy or problem. If the EUTF is not notified in writing within the 90 days, the EUTF reports shall be considered as final and accepted by the Contractor.

4.18 AVAILABILITY OF FUNDS

The contract shall be enforceable only to the extent that funds are available to the EUTF to make payments to the Contractor. All payments to the Contractor are subject to the EUTF's actual and continuing availability of funds. No damages or interest shall accrue against the EUTF, the State, the counties, or any other public employer as a result of the non-availability of funds.

The Contractor acknowledges that the funds available to the EUTF come from public employer and employee-beneficiary contributions. With respect to retirees, HRS chapter 87A establishes the amount of the public employer contributions. However, with respect to active employees, the public employer contributions are generally established by collective bargaining between the public employers and public sector unions, and such contributions are subject to appropriation by the legislative bodies of the State and counties. See HRS §§ 87A-32, 89-9(a), 89-9(e), 89-10(b), and 89-11(g). Thus, a significant portion of the EUTF's availability of funds is contingent upon future collective bargaining between the public employers and public sector unions, the terms of any

resulting collective bargaining agreements, and future appropriations by the legislative bodies of the State and counties.

The EUTF shall have the following rights should there not be available funding for the Contractor's contract: (a) to cancel the award of contract; (b) to renegotiate the award of contract to purchase reduced or modified services; (c) to delay the commencement date of the contract; or (d) to terminate the contract partially or in its entirety.

4.19 AUDIT REQUIREMENTS

1. Audit Rights. The EUTF or its designee will have the right to audit annually, with full cooperation of the Contractor, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the PBM Contractor, to verify compliance with all program requirements and contractual guarantees at no additional charge.

   The EUTF will not be held responsible for time or miscellaneous costs incurred by the Contractor in association with any audit process, including all costs associated with provision of data, audit finding response reports, or systems access, provided to the EUTF or its designee during the life of the contract and period after the contract equal to the term of the contract including extensions. **Note**: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.

   PBM Services: The rebate audit will be conducted separately from the claims audit. The EUTF or its designee will have the right to audit pharmaceutical manufacturer rebate contracts that account for 75% of the total rebate payments during the selected audit period during an on-site rebate audit.

2. Auditor. The EUTF or an independent auditor retained by EUTF, may review 100% of the claims and rebates.

   PBM Services: Any independent auditor retained by EUTF must meet the following criteria: (a) is a public accounting firm that is a member of the American Institute of Certified Public Accountants (AICPA), or a reputable consulting firm with a benefit consulting practice that operates nationally and adheres to generally accepted accounting and actuarial principles, provided that, with respect to any audits of pharmaceutical manufacturer rebate contracts or retail network pharmacy contracts, such consulting firm maintains an information "fire wall" between its consulting and auditing divisions; (b) has not previously breached a confidentiality agreement with the Contractor; (c) does not currently provide audit or consulting services or advice to any person, company or other entity in connection with any lawsuit, investigation or other proceeding related to EUTF or the PBM; and (d) enters into a confidentiality agreement with the Contractor that is reasonably acceptable to the Contractor and EUTF prior to commencing any audit activities and carries insurance for professional malpractice of at least two million dollars ($2,000,000).

3. Audit Period. The EUTF or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and the Contractor will provide all documentation necessary to perform the audit. The EUTF may conduct such audit every year

regardless of when the prior audit was conducted as long as the audit period has not been previously audited. The EUTF shall be able to initiate a new audit even if all parties have not agreed that the prior audit is closed.

PBM Services: The EUTF or its designee will have the right to audit up to the last four complete contractual years (48 months) of claims at no additional charge from the PBM Contractor as long as the audit period has not been previously audited. All audits shall not be limited to information relating to the plan year in which the audit is conducted or the immediately preceding plan year.

4. Audit Sample Size. The Contractor shall agree to provide a claim sampling size to the auditor sufficient to meet the required confidence rate of 95% with a plus or minus 3% precision (expected error rate not to exceed 3%). The Contractor shall not set a maximum number of claim samples per audit regardless of whether the scope of the audit is for one year or multiple contractual years.

5. Response Time. The Contractor shall provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the Contractor.

   The Contractor shall provide full responses to all of the sample claims and claims audit findings, including suspected errors, regardless of the number of claim samples sent to the Contractor or the number of years that encompass the scope of the audit, within 30 days of receipt of the audit findings.

6. Auditing and Consulting Costs. Contractor shall share in audit and consulting costs related to the health benefit plans procured by the EUTF in the following amounts for each year of the contract:

   a. PPO/HMO Plans – $100,000 (includes both active and retiree plans)
   b. Closed Panel HMO Plans – $50,000 (includes both active and retiree plans)
   c. Supplemental Medical and Prescription Drug Plans – $20,000
   d. Pharmacy Benefit Active and Retiree contract – $200,000 (includes both active and retiree plans)

   If the aforementioned amounts are not used by the EUTF to offset audit and consulting costs, the EUTF may carry the remaining amounts to the next year of the contract or be refunded to the EUTF.

4.20 PREMIUM HISTORY

The monthly tiered employer and employee contribution rates for current and previous years are shown in Exhibit B, *Premium Rates* by carrier and subscriber type for all plans.

4.21 FEDERAL AND STATE LAWS, RULES AND REGULATIONS

The Contractor shall apprise the EUTF of any current or new federal or state laws, rules, or regulations that affect the EUTF medical and prescription drug plans, including, but not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)
2. Consolidated Omnibus Budget Reconciliation Act (COBRA)
3. Mental Health Parity and Addiction Equity Act of 2008
4. Patient Protection and Affordable Care Act (ACA)
5. Consolidated Appropriations Act, 2021
6. Inflation Reduction Act of 2022 (IRA)
7. CMS rules and regulations pertaining to Medicare

The Contractor shall: (a) notify the EUTF of any new or changes in laws, rules, and regulations, (b) perform periodic assessment of the EUTF's efforts to comply with such laws, rules, and regulations, including updating its policies, procedures, notices, and plan design, and (c) assist the EUTF to ensure compliance of such laws, rules, and regulations.

4.22 CONTRACT TERMS

1. Implementation. If a new Contractor is selected (to provide a fully insured prescription drug benefit or to administer the self-insured prescription drug benefit), the Contractor must agree to load all current prior authorizations, open mail order refills, specialty transfer files, claim history files, and accumulator files that exist for current members from the existing PBM at no charge to the EUTF (with no charges being deducted from the implementation credit for file loading or IT) even if the EUTF terminates the contract with or without cause at any point of the contractual term.

   PBM Services: The PBM Contractor must agree to waive any charges (such as a set-up fee, a programming fee, or a monthly fee) to the EUTF or the EUTF's medical plan claims administrator for establishing a connection with a third-party administrator/claims processor for real-time, bidirectional data integration, including non-standard data integration formats.

   The PBM Contractor must agree to provide a fund of at least $75,000 for an Implementation Audit which shall be conducted at least 60 days prior to the start of claims adjudication. The PBM Contractor shall work with the auditor to run test claims in a test environment utilizing the EUTF's actual plan parameters. If provided in Attachment 11, *PBM Proposal*, the EUTF shall also be able to use the General Administrative Credit or Implementation Credit for Implementation Audit costs.

2. Termination. Refer to Section 1.29.8, *Transition Procedures*. The audit provision as described in Section 4.19, *Audit Requirements*, shall survive the termination or expiration of the contract for a period equal to the term of the contract including extensions at no additional cost.

   PBM Services: The EUTF will have the right to terminate the contract with cause at any time with 30 days' notice without penalty if an effective remedy is not provided to the satisfaction

of the EUTF. The EUTF will have the right to terminate the contract without cause at any time with 90 days' notice without penalty.

Fees proposed for all administrative services under a self-insured proposal must include the payment of all run-out claims after the termination or expiration of the contract. The fees charged during the term of the contract are to include all of the post termination services in addition to claim adjudication and payment, including financial reporting, claim appeal processing, management of the self-funded banking arrangements, eligibility and retroactive adjustment to eligibility and continuation of COBRA processing for the participants enrolled in COBRA benefits at the time of termination Run Out Claim Administration. Upon termination of the contract, the PBM Contractor will be required to pay all run-out claims for twelve months after the termination. All fees in this proposal are to include the cost of all post termination administration of the self-insured plan if the option of self-insured plan administration is elected by the EUTF. No charges other than benefit cost will be paid after the termination of the contract. The EUTF will not repay any remaining balance of the contract credits provided in Attachment 11, *PBM Proposal* if the contract is terminated early with or without cause.

The financial guarantees for any partial contractual year that results from an early termination will still be guaranteed, reconciled and the PBM Contractor will still make payments for any shortfalls for those resulting partial contractual years with less than 12 months. All rebate revenue earned by the EUTF under the contract shall be paid to the EUTF regardless of their termination status as a client. Lag rebates on claims incurred prior to the termination date will continue to be paid to the EUTF after termination until 100% of earned rebates are paid.

The PBM Contractor must agree to send at least the most current 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the EUTF members to the next/successor PBM at no charge even if the EUTF terminates the contract with or without cause at any point of the contract term.

3. Market Check (for PBM contract only). The PBM Contractor must agree to a mid-contract term market check, which may start as soon as the second quarter of the second contract year, conducted by an independent third party to ensure the EUTF is receiving appropriate current pricing terms competitive within the industry based on its volume and membership, and will improve pricing in the event that the EUTF's contract terms are less than current. The PBM Contractor will review the financial terms of the EUTF compared to the financial offering presented to similar employers in the marketplace as deemed appropriate as part of this process and offer improved pricing to the EUTF. The EUTF will have the right to terminate the contract without penalty if EUTF does not agree with the revised pricing terms. The improved pricing terms will become effective on the first day of the third year of the contract.

PBM SCOPE OF WORK

5.1 BACKGROUND

Active employees are currently offered a self-insured prescription drug plan administered by CaremarkPCS Health, LLC (CVS) which are bundled with HMSA medical plans. Non-Medicare retirees are also offered a self-insured prescription drug plan administered by CVS but have the option of also enrolling in the HMSA medical plan or enrolling in the prescription drug plan only. Medicare retirees are offered a Medicare Part D EGWP administered by SilverScript Insurance Company (SSI) and have the option of also enrolling in a HMSA or Humana medical plan or enrolling in the prescription drug plan only. The EUTF also has a specialty carve-out arrangement where specialty drugs, when dispensed from a provider other than a retail or specialty pharmacy, can be covered under the HMSA medical plan.

5.2 PBM SERVICES

During the entire term of the contract, the PBM Contractor shall provide comprehensive PBM services including but not limited to the following:

1. Services described in Section IV, *Scope of Work* (unless otherwise specified)
2. Ability to integrate PBM services with medical vendors, as applicable
3. Electronic eligibility maintenance
4. Pricing administration
5. Formulary management and rebate sharing
6. Pharmacy network management
7. Mail order program
8. Specialty drug program
9. Systematic prospective, concurrent, and retrospective Drug Utilization Review
10. Member and provider communication, including notification of formulary and/or copay changes and distribution of new enrollee material
11. Complete availability of IT services, including online/real-time availability to EUTF and/or its designee(s)
12. Clinical programs (including a safety and monitoring program)
13. Disease management: MTM (Medication Therapy Management Program)
14. Provide an EGWP for Medicare eligible retirees in medical PPO plan and adhere to CMS EGWP guidelines

5.3 DEFINITIONS

1. Generic Drugs. The term "Generic Drug(s)" shall mean the following: The Multisource Code field in MediSpan contains a "Y" (generic). Claims submitted with a Multisource Code field in MediSpan containing the value of "O" and also submitted with a DAW Code of 3, 4, 5 or 6 shall also be considered a Generic Drug. When a drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing the EUTF, determining the copayment or coinsurance to be paid by the Plan Beneficiary, and calculating the satisfaction of guarantees

and generic dispensing rate guarantees unless otherwise specified in Section 5.5, *Financial Terms*. Generic drugs include single-source generics or authorized generics from at least one FDA-approved generic manufacturer with exclusivity, limited supply, limited availability, or limited competition and "House Generics"/DAW 5 brand claims. The EUTF will not pay more for any "House Generics"/DAW 5 brand claim than its generic equivalent before rebates.

2. Brand Drugs. The term "Brand Drug(s)" shall mean the following: The Multisource Code field in MediSpan contains an "M" (co-branded product), or an "N" (single source brand), or an "O" (originator brand) (except where the claim is submitted with a DAW Code of 3, 4, 5 or 6 in which case it shall be considered a Generic Drug). Claims with a Multisource Code of "O" and with a DAW Code of 0, 1, 2, 7, 8 or 9 shall be considered a Brand Drug. When a drug is identified as a Brand Drug, it shall be considered a Brand Drug for all purposes by OFFEROR, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing the EUTF, determining the copayment or coinsurance to be paid by the Plan Beneficiary, and calculating the satisfaction of guarantees and generic dispensing rate guarantees unless otherwise specified in Section 5.5, *Financial Terms*.

3. Specialty Drugs. The term "Specialty Drug(s)" shall mean each NDC-11 drug mutually agreed upon by execution of a contract. The term "Specialty Drug" shall also include any new-to-market specialty drug that the EUTF approves the dispensing of, in writing. The EUTF shall have the right to select which Specialty Drugs shall (or shall not) be dispensed to its Plan Beneficiaries. The EUTF will not pay for medical supplies and services in the dispensing/usage of specialty medications not covered by the EUTF prescription drug plan.

4. Pass Through and Transparent. The PBM Contractor shall pass through 100% of negotiated discounts with network pharmacies at the point-of-service and with no pricing spread between what is paid to the pharmacy and invoiced to the EUTF. The PBM Contractor shall provide auditing protocol, enabling tracking of individual claims back to original pharmacy network contract documents. The PBM Contractor shall pass through 100% of all rebate revenue earned and shall not charge an administrative fee for this arrangement. The PBM Contractor shall also agree to disclose details of all other programs and services generating financial renumeration from outside entities, including manufacturers, pharmacies, and retailers.

5. Rebates. Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access. The PBM Contractor shall agree to provide drug-level rebate information.

6. Average Wholesale Price (AWP). AWP is based on the actual date sensitive, 11-digit National Drug Code (NDC) for the strength and form of the drug being dispensed as supplied by a nationally recognized pricing source (i.e., MediSpan) for retail, mail order, and specialty adjudicated claims (subject to outstanding litigation). The PBM Contractor shall notify the

EUTF of any change to the AWP source at least 180 days in advance of the change. Any change must be based on a book of business decision and apply to clients similar to the EUTF. Any change must also be price neutral and acceptable to the EUTF.

7. Member Copay. Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted ingredient cost plus dispensing fee, usual and customary charges (if at retail), MAC (maximum allowable cost) or cash price at retail, mail and specialty pharmacies. The impact of MAC price increases on member cost share shall not exceed 25% from one quarter to the next.

8. Members. All eligible employees, retired employees, and their eligible dependents enrolled under the EUTF's prescription benefit program.

9. Paid Claims. Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the EUTF or the EUTF member copays. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.

10. Client Eligibility and Claims Data. All eligibility and claims records are the sole property of the EUTF and must be made available upon request to the EUTF and its representatives. Selling or providing of the EUTF's data to any outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the EUTF. Even if the Contractor has not "sold" the data, it is not free to use the data for analyses that it publishes or provides to outside industries.

5.4 FORMULARY

1. Current Formulary. The EUTF active employee and non-Medicare retiree plans have an open non-specialty formulary and closed specialty formulary (called the CVS Standard Opt Out Formulary with Advanced Control Specialty Formulary). The HSTA VB active employee and non-Medicare retiree plans have both an open non-specialty and specialty formulary (called the CVS Standard Opt Out Formulary). The EUTF and HSTA VB EGWP plans have a Medicare Part D formulary (called the SSI Bronze Formulary) with a wrap that provides additional coverage. The current formulary shall be grandfathered for 90 days following the contract effective date, with no impact on rebate guarantees.

   The current formularies can be found online through the links provided on the EUTF website: https://eutf.hawaii.gov/health-life-insurance-providers/cvs/contact-information/

   Note: If a drug product is listed on both the preferred drug list and exclusion list, the exclusion list takes precedence.

2. Open Formulary Management. The PBM Contractor shall not implement, administer, or allow any program that results in greater utilization of higher cost drug products than lower cost drug products or increases the member cost share without prior written consent from the EUTF or its designee. The EUTF intends to maintain an open non-specialty formulary. All non-specialty drug exclusions and utilization management must be approved by the EUTF Board.

3. Closed Formulary Management. The PBM Contractor shall not remove non-specialty (if the EUTF Board moves to a closed formulary) and/or specialty products (other than FDA recalls and for other safety reasons) more than quarterly. The PBM Contractor shall notify the EUTF or its designee 90 days in advance of when a drug is targeted to change tier or be moved to/from the non-specialty and specialty preferred drug list. The PBM Contractor must provide a detailed disruption and financial impact analysis at the same time. Member disruption by any non-specialty and specialty formulary deletions (or all deletions in total) on an annual basis shall not exceed 2%.

   The PBM Contractor shall notify the EUTF or its designee at least 60 days prior to changing the specialty classification of a drug (i.e., from non-specialty to specialty or vice versa).

5.5 FINANCIAL TERMS

The administrative fees and guarantees provided in Attachment 11, *PBM Proposal*, shall be guaranteed for the term of the contract unless otherwise agreed upon after the market check described in Section 4.22, *Contract Terms*. The PBM Contractor shall agree to absorb any other administrative fees or costs to meet any current or future federal or State requirements, including, but not limited to the ACA and IRA. All guarantees shall include Medicare Part D drugs and products subject to patent actions.

1. Non-Rebate Pricing Guarantees. All pricing guarantees shall be calculated using AWP as defined in Section 5.3, *Definitions*, be calculated before the application of member cost share (including member paid penalties) and include zero balance due claims (or zero amount claims). Each distinct non-rebate pricing guarantee (including discount and dispensing fee guarantees) shall be measured and reconciled on a component basis only (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty brand and generics at participating retail pharmacies, and specialty brand and generics at the PBM's Specialty Pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the EUTF. Specialty dispensing shall be limited to a 30-day supply. A surplus in one component (including rebates) may not be utilized to offset a deficit in other components.

   a. AWP Discount Guarantees. AWP discount guarantees shall be minimum guarantees, a discount from 100% AWP, and based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback. AWP discount guarantees shall be calculated as follows: *1 – Aggregate Ingredient Cost / Aggregate AWP*

      Aggregate AWP is the date sensitive, 11-digit NDC of the actual product dispensed. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication shall be used in the calculation.

   b. Specialty Overall Effective Discount (OED) Guarantees. Specialty OED guarantees shall include biosimilars and limited/exclusive distribution drugs. If new to market (NTM) specialty drugs, biosimilars, and limited distribution drugs are not included in the specialty

OED guarantees, provide the discount guarantees separately in Attachment 11, *PBM Proposal*.

c. Dispensing Fee Guarantees. Dispensing fee guarantees shall be maximum guarantees per prescription dispensed (not based on adjustments, errors, or redos). The mail order and specialty drug dispensing fees shall remain constant throughout the contract term and will not be increased due to any increase in postage charges, including U.S. mail and commercial courier service charges.

2. Rebate Guarantees. Rebate guarantees shall be minimum guarantees applied to all brand drugs as defined in Section 5.3, *Definitions* (including multi-source and formulary excluded brand claims), biosimilars, diabetic strips, single source generics, and "House Generics"/DAW 5 brand claims. All rebates (including any administrative fees and Inflation Protection Payments paid by manufacturers) shall be based on drug-level rebate data and 100% passed through to the EUTF. The rebate guarantees shall exclude member cost share. Each distinct rebate guarantee shall be measured and reconciled on a component basis only (e.g. retail 30 brand, retail 90 brand, mail order brand, and specialty drugs at participating retail pharmacies including the PBM's Specialty Pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the EUTF. A surplus in one component may not be utilized to offset a deficit in other components. Rebate surpluses will not be utilized to offset deficits in any other non-rebate guaranteed component.

   Within 90 days after the end of each quarter, the PBM Contractor shall pay to the EUTF the rebate payments based on minimum rebate guarantees and provide a detailed report listing the number of brand drugs per delivery channel, rebate amount per brand drug at each delivery channel, and the resulting minimum guaranteed rebate payment per delivery channel owed to the EUTF as well as the rebates received by the PBM Contractor from manufacturers for the EUTF's utilization.

   Within 90 days after the end of each contract year, the PBM Contractor shall pay to the EUTF, any shortfall between the rebates paid and the greater of the minimum rebate payments or the rebates invoiced by the PBM Contractor for the EUTF's utilization, on a dollar-for-dollar basis, and provide an annual rebate reconciliation report.

3. Generic Dispensing Rate (GDR) Guarantees. GDR guarantees shall be measured and reconciled on a component basis (Retail, Mail Order, and Specialty) and a shortfall in one delivery channel will not be used to offset a shortfall in another delivery channel or any other financial component guarantee. The GDR shall include only true instances of generic dispensing (excluding multi-source brand drugs dispensed under member-pay-difference plan designs) and shall exclude copays and rebates from the calculation.

4. Trend Guarantee. The Non-Specialty Gross Drug Spend per member per year trend shall not exceed 6%. The year over year percentage increase in the Generic Drug Ingredient Cost compared on a contract year basis shall not exceed 2% throughout the term of the contract.

Retail 30 pricing and rebate guarantees shall apply to all claims that adjudicate at the retail 30 network with 1-83 days' supply (including applicable claims from all 50 states and the District of

Columbia). Retail 90 pricing and rebate guarantees shall apply to all claims that adjudicate at the retail 90 network with 84-90 days' supply. Mail order pricing and rebate guarantees shall apply to all claims that adjudicate at mail regardless of days' supply. Specialty pricing and rebate guarantees shall apply to all claims that adjudicate at retail pharmacies and the PBM's Specialty Pharmacy which are limited to 30 days' supply.

The pricing and rebate guarantees shall exclude any savings impact from drug utilization review (DUR) programs, formulary programs, utilization management programs, and/or other therapeutic interventions and shall not be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by the PBM Contractor.

The financial reconciliation shall use the AWP pricing at the point of adjudication or the retroactive AWP pricing that the pricing source issues, whichever is less. Within 90 days after the end of each contract year, the PBM Contractor shall pay to the EUTF any shortfall between the actual result and the guarantee, on a dollar-for-dollar basis. Any shortfall amount between the actual result and the guarantee that is not paid to the EUTF within 90 days after the end of each contract year, shall accrue a pro-rated 2% monthly late fee.

5.6 RETAIL PHARMACY NETWORK

1. Current Pharmacy Network. In addition to using the CVS Caremark Retail Network, the EUTF active employee and non-Medicare retiree plans also use a narrower network (called the Retail 90 Pharmacy Network) where members can receive a 90-day supply for two 30-day supply copayments. The pharmacy network used for the EGWP shall meet CMS requirements. Contractor shall provide a written description of EGWP network structure and participation requirements. No change in administrative fees shall occur during the contract term without written consent from the EUTF.

2. Network Reduction. The PBM Contractor shall notify the EUTF at least 180 days in advance of any event (unless unforeseeable such as an act of God) or negotiation that may negatively impact the retail pharmacy network and at least 60 days in advance of the removal of a participating pharmacy that dispenses more than 2% of the EUTF's prescriptions from the retail network. If such a change is not agreeable to the EUTF, the EUTF reserves the right to terminate the agreement without penalty with 90 days' notice. The EUTF also reserves the right to remove any pharmacy from its retail pharmacy network.

5.7 MAIL ORDER PROGRAM

1. Mail Order Fulfillment Center. The PBM Contractor shall have a mail order fulfillment center located in Hawaii.

   Mail Order Pricing. Mail order pricing shall apply to all prescriptions dispensed through mail order facilities. Mail order unit cost prior to member cost sharing, dispensing fees, and sales tax shall be no greater than the unit cost for the same NDC-11, adjusted for quantity and days' supply, at retail on the same day. If the EUTF identifies any situation in which the EUTF paid more for a prescription at mail than it would have paid at retail on the same day,

including U&C pricing, the PBM Contractor shall reimburse the EUTF on a dollar-for-dollar basis.

The PBM Contractor shall be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM Contractor shall not invoice the EUTF for any uncollected member cost shares even if there is a debit threshold in place.

2. Mail Order Benefit. Be advised that Act 226, SLH 2013 (HB65) specifically prohibits the preference of a mail order pharmacy, by way of any inducement in plan design or requirement, when contrasted to the OFFEROR's retail pharmacy network. This includes any carve out of specialty medication or requirements that are in any way less favorable to a retail pharmacy when compared to a mail order service facility. OFFERORS are required to fully comply with all state legislation, including this law.

   Act 226, SLH 2013 can be found at:
   https://www.capitol.hawaii.gov/slh/Years/SLH2013/SLH2013_Act226.pdf

5.8 DRUG UTILIZATION REVIEW

The Contractor shall have a Drug Utilization Review (DUR) program in place that includes concurrent DUR, retrospective DUR, and prior authorizations. All network pharmacies must be able to access and edit real-time plan information including but not limited to eligibility, drug price, drug tier and member cost share, duplicate therapies, proper drug for the condition being treated, proper drug dosage and day supply, drug interactions, generic alternatives, prescription refills, and coordination of benefits with other non-EUTF plans.

5.9 EMPLOYER GROUP WAIVER PLAN (EGWP)

The objective of the EGWP portion of this RFP is to solicit competitive proposals from qualified bidders that will offer high quality, cost effective prescription drug benefits through an EGWP (Medicare Part D with Wrap) to the EUTF's Medicare-eligible members. The EUTF requires matching the existing plan design and incurring minimal disruption to the current drug formulary and pharmacy network.

1. EGWP Enrollment. Refer to Exhibit C, *EUTF Administrative Rules* for termination of enrollment rules. The EUTF's benefits administration system allows for retroactive terminations (e.g., non-payment of premiums or divorces) however, the EGWP plan administered by the PBM will maintain coverage in accordance with CMS rules and regulations that provide only prospective terminations. **Note**: EUTF's benefits administrative system does not normally cancel/terminate Medicare retirees prospectively.

   The following are scenarios on how an EGWP enrollment shall be processed:
   a. The 834 file sent on 1/7/25 shows that a non-Medicare retiree or spouse became Medicare eligible on 1/1/25. Thus, the retiree or spouse will need to move from the non-Medicare retiree plan to the EGWP plan for coverage effective 3/1/25.

b. The EGWP 834 file shows that a new Medicare retiree enrolls in the plan with a non-Medicare spouse or vice versa on 1/1/25. Your system must have the capability to cover the Medicare retiree in the EGWP plan and the non-Medicare spouse in the commercial plan or vice versa (even though the non-Medicare spouse does not show up on the commercial 834 file).

2. EGWP Formulary. Refer to Section 5.4, *Formulary* for formulary requirements. Contractors will ensure compliance with all CMS guidance, rules and regulations related to Part D formularies.

3. EGWP Pharmacy Network. Refer to Section 5.6, *Retail Pharmacy Network* for network requirements. Contractors will ensure compliance with all CMS guidance, rules and regulations related to pharmacy networks.

5.10 PROVIDER AUDITS

The PBM Contractor shall not charge the EUTF or offset any costs from an audit performed on a contracted pharmacy (including mail order and specialty pharmacies) even if the PBM Contractor has to pursue additional collection to recover pharmacy audit discrepancies. The PBM Contractor shall not withhold any financial recoveries from a pharmacy audit. Any and all recoveries shall be disclosed and credited to the EUTF.

As part of the annual claims audit described in Section 4.19, *Audit Requirements*, the EUTF or its designee shall be able to fully inspect pharmacy provider contracts for up to 80% of retail pharmacy claims under the pass-through pricing arrangement.

PROPOSAL DOCUMENTS

6.1 OFFEROR INFORMATION SHEET

Attach as Schedule 1, Attachment 7, *Offeror Information Sheet*.

OFFEROR must provide three current client references with over 5,000 covered lives (preferably public sector clients) for whom medical benefits or pharmacy benefit management services are provided. Client references should include the following:

1. A current client that has been with the OFFEROR for three years
2. A new client that went through the implementation process within the past 6-12 months
3. A client that is no longer a client of the OFFEROR's

The OFFEROR must provide a minimum of three client references. If the OFFEROR cannot provide a client reference as described in #2 or #3 above, the OFFEROR can provide a client reference as described in #1 in its place. These clients will serve as the OFFEROR's references. The EUTF's Consultant will contact the references directly.

6.2 KEY PERSONNEL

Attach as Schedule 2, identify members of the EUTF account team. Include their name, job title, professional licenses and certifications, duties and responsibilities, years of experience, number of assigned accounts, and contact information (including business addresses, email addresses, and telephone numbers). Include resumes or biographies as well.

The EUTF account team shall include, but not be limited to, the following:

- Local Account Manager
- Senior Account Manager (supervisor of above)
- Enrollment Manager
- IT Manager
- Clinical Advisor (medical benefits) or Clinical Pharmacist (PBM services)
- Implementation Manager (if necessary)

Indicate which team member will serve as the contract liaison officer as described in Section 4.6, *Meetings*.

6.3 FINANCIAL STATEMENTS

Attach as Schedule 3, evidence of the OFFEROR's financial stability (e.g., audited financial statements or latest annual report).

OFFERORS shall provide a copy of its most recent external rating from: Standard & Poor's, Fitch, Moody's, or A.M. Best. OFFEROR shall indicate if there has been any downgrade in its ratings in the last two years. If the OFFEROR's company is not rated by any of these agencies, submit documentation of a similar nature which attests to its financial stability. If the OFFEROR is not

able to submit evidence with the proposal, the OFFEROR must agree to submit evidence if selected as a PLO.

6.4 MEDICAL QUESTIONNAIRE

Attach as Schedule 4, Attachment 8, *Medical Questionnaire*.

Provide answers to the questionnaire in Word format using the template provided. Do not alter the questions or question numbering.

The OFFEROR must complete all sections of the questionnaire and provide an answer to each question even if the answer is "not applicable" or "unknown." Answer the questions as directly as possible. For example, if the question asks, "How many…" provide a number. If the question asks, "Do you…" indicate Yes or No followed by a brief explanation to clarify if necessary.

Important: Be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 200 words in length so that the response contains the most important points. Referring to an attachment for further information should be avoided or limited as much as possible. Any response that does not directly address the question and that only contains marketing information will be considered non-responsive. OFFERORS will be held accountable for the accuracy and validity of all answers. For the Supplemental Medical and Prescription Drug Plan, OFFERORS (at its discretion) can indicate "NA" where questions do not apply.

The submission of a proposal will be deemed a certification that the OFFEROR will comply with all requirements set forth in this RFP. If multiple plan options are requested, it will be assumed that all answers apply equally to all plan options. If this is not the case, separate answers should be provided for each plan option. RFP responses will become part of the contract between the successful OFFEROR and the EUTF.

6.5 PLAN SUMMARIES AND FEE PROPOSAL

Attach as Schedule 5, Attachment 9, *Plan Summaries and Fee Proposal*.

1. Proposed Benefits. Detailed benefits information is provided in Exhibit E, *Evidence of Coverage Documents*. The EUTF is requesting that OFFERORS match the current benefits. If you are unable to match the benefits, please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. If you are matching the current benefit, but are recommending a revision to the current benefits, please note the recommendation and provide separate pricing for the revision.

2. Fee Proposal. The Excel file submitted in response to this RFP must include your proposed fees and rates. Please print the completed proposal forms for the hard copy submissions of your proposal.

   [Note: For all of the following Sections, please read the instructions to OFFERORS concerning the disclosure of "trade secret" or "confidential" information and mark your

responses in this RFP accordingly. Failure of the OFFEROR to appropriately identify the responses as such may result in the disclosure of any such information.] Please refer to the instructions for the submission of a redacted copy of your proposal in Section 1.11, *Submission of Proposals*.

Notes Applicable to Insured/Risk Sharing Proposed Rates

1. All proposals are to be all inclusive of expenses and charges. The EUTF will not pay an additional amount for any ancillary charges for any items, including, for example, overhead, travel, telephone, local office expenses, shipping or printing.

2. All proposals must include all fees and taxes, including those associated with data submissions to Segal's data warehouse (SHAPE) and the Hawaii All-Payer Claims Database. The EUTF will reimburse the Contractor for the ACA PCORI fee.

3. All proposals must guarantee a fixed administration, plus retention profit, and DM/IHM fees as a fixed fee per employee/retiree per month. This guarantee must be separately stated for the initial contract term and the optional contract extensions.

4. You must separately list the guaranteed retention/administrative cost and profit on your proposal sheet for the fully insured options.

5. For the fully insured plans with risk sharing, if the total benefit paid for all plans under the contract at the end of the runout period is less than the proposed benefit cost for all plans under the contract, the excess amount will be refunded to the EUTF. Offsetting of plan surpluses and deficits within the same contract (e.g., an EUTF PPO 80/20 surplus in Year 1 may offset a HSTA VB PPO 80/20 deficit in Year 1) is allowed. However, an EUTF PPO 80/20 surplus in Year 1 **may not** offset a EUTF non-Medicare retiree PPO 90/10 deficit in Year 1 since they are under difference contracts. See example below. The financial reconciliation will be for each plan year (including extensions) without the ability to carry-forward deficits or surpluses from one plan year to the next. The EUTF retiree PPO plan for non-Medicare and Medicare retirees is considered one plan but is separate from the HSTA VB PPO plan for non-Medicare and Medicare retirees which is another plan, but both are part of the same contract.

   OFFERORS should propose a percentage discount off the administration and retention fees, if offsetting of plan surpluses and deficits is allowed over the entire contract period including extensions. The percentage discount should be specific to each period in the entire contract period including extensions. However, the active contract may not be merged with the retiree plan contract to offset deficits or surpluses. The two contracts must be accounted for independently.

Initial Reconciliation

Contractor agrees to an initial reconciliation that shall occur with six months of benefits run-out following the end of the contract period and a final reconciliation that shall occur with 12 months of benefits run-out following the end of the contract period. Both reconciliations will be done within 45 days after the respective run-out periods.

The initial reconciliation shall include all plans under the contract and be calculated as follows: Paid premiums (excluding ACA PCORI fees), minus paid benefits, minus administration, retention and DM/IHM fees, minus reserves for incurred but not reported benefits. Administration, retention and DM/IHM fees shall be calculated by multiplying the fixed dollar amounts (per subscriber per month rates) by the number of subscribers in each month of the contract period. Any surplus shall be returned to EUTF (Example 1). Any deficit shall be the responsibility of Contractor (Example 2).

Example #1: Surplus returned to EUTF

$1,000,000	paid premiums
-$750,000	minus paid benefits
-$60,000*	minus administration, retention, DM/IHM fees
-$100,000	minus reserves for incurred but not reported benefits
$90,000	surplus paid to EUTF

*$4.00 per subscriber per month ($4.00 is an example only) x 15,000 (sum of enrolled subscribers in each month of the contract period) = $60,000

Example #2: Deficit is the responsibility of the Contractor

$1,000,000	paid premiums
-$850,000	minus paid benefits
-$68,000*	minus administration, retention, DM/IHM fees
-$100,000	minus reserves for incurred but not reported benefits
-$18,000	Contractor may not invoice EUTF

*$4.00 per subscriber per month ($4.00 is an example only) x 17,000 (sum of enrolled subscribers in each month of the contract period) = $68,000

Final Reconciliation

The final reconciliation shall include all plans under the contract and be calculated as follows: Paid premiums (excluding ACA PCORI fees), minus paid benefits, minus administration, retention, DM/IHM fees, minus reserves for incurred but not reported benefits (which will be calculated based upon the previous plan year run-out of claim experience for months 13-24 but not more than 0.2% of plan year benefits). Administration, retention, DM/IHM fees shall be calculated by multiplying the fixed dollar amounts (per subscriber per month rates) by the number of subscribers in each month of the contract period.

If the final reconciliation surplus is greater than the initial reconciliation surplus, then the surplus from the final reconciliation less any surplus paid to the EUTF for the initial reconciliation shall be returned to the EUTF (see example 1a). If the final reconciliation surplus is less than the initial reconciliation surplus, the Contractor may invoice EUTF for the difference (see example 1b). If the initial reconciliation resulted in a surplus and the final reconciliation resulted in a deficit, Contractor may invoice EUTF the amount of the initial reconciliation surplus (see example 1c).

Example #1a: (Contractor paid EUTF $90,000 refund at initial reconciliation):

$1,000,000	paid premiums
-$840,000	minus paid benefits
-$60,000	minus administration, retention, DM/IHM fees
-$1,092	minus incurred but not reported benefits (for active employees, the calculation is $840,000 x 0.0013)*
$98,908	final reconciliation surplus
-$90,000	minus initial reconciliation surplus paid to EUTF
$8,908	additional surplus to be refunded to EUTF

Example #1b: (Contractor paid EUTF $90,000 refund at initial reconciliation):

$1,000,000	paid premiums
-$900,000	minus paid benefits
-$60,000	minus administration, retention, DM/IHM fees
-$1,170	minus incurred but not reported benefits (for active employees, the calculation is $900,000 x 0.0013)*
$38,830	final reconciliation surplus

Contractor may invoice EUTF for $51,170, which represents the difference between the initial reconciliation refund and the final reconciliation surplus ($90,000 - $38,830 = $51,170).

Example #1c: (Contractor paid EUTF $90,000 refund at initial reconciliation):

$1,000,000	paid premiums
-$1,000,000	minus paid benefits
-$60,000	minus administration, retention, DM/IHM fees
-$1,300	minus incurred but not reported benefits (for active employees, the calculation is $1,000,000 x 0.0013)*
-$61,300	final reconciliation surplus

Contractor may invoice EUTF for the $90,000 initial reconciliation surplus.

If the initial reconciliation resulted in a deficit, and the final reconciliation also results in a deficit, Contractor shall not invoice EUTF (see example 2a). If the initial reconciliation resulted in a deficit, and the final reconciliation results in a surplus, the surplus from the final reconciliation shall be returned to EUTF (see example 2b).

Example #2a: (Contractor had an $18,000 deficit at initial reconciliation):

$1,000,000	paid premiums
-$960,000	minus paid benefits
-$68,000	minus administration, retention, DM/IHM fees
-$1,248	minus incurred but not reported benefits (for active employees, the calculation is $960,000 x 0.0013)*
-$29,248	final reconciliation deficit

Contractor may not invoice EUTF for the final reconciliation deficit.

Example #2b: (Contractor had an $18,000 deficit at initial reconciliation):

$1,000,000	paid premiums
-$850,000	minus paid benefits
-$68,000	minus administration, retention, DM/IHM fees
-$1,105	minus incurred but not reported benefits (for active employees, the calculation is $850,000 x 0.0013)*
$80,895	final reconciliation surplus to be refunded to EUTF

*Amount is for example purposes only.

6. Deficits may not be carried forward to subsequent contract periods to be recovered from any future surplus. Each contract plan year must be separately accounted, and surpluses must be returned 12 months after the conclusion of each plan year.

7. The EUTF reserves the right to offer multiple carrier options.

8. No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

9. Rates must be quoted on a three-tiered basis (self, two-party, and family). If this is not possible due to federal filing requirements, please note that exception clearly on each rate table that you are completing, but you must guarantee your retention/administrative fee and profit for the entire contract period and successive periods.

10. All underwriting rules/restrictions that apply to rates quoted must be listed as an attachment to the rate exhibit.

11. All rates quoted must exclude any commissions or payment to any third party.

12. Please list any rating method which uses a credibility factor less than 100% in your underwriting assumptions.

13. Rates must be filled out in the proposal sheets provided.

14. All rates must be guaranteed for the term of the contract including the proposed extensions (see Section 1.4, *Contract Period*).

15. If your proposal is accepted by the EUTF, the following additional rates will be required for various self-pay categories: Tiered COBRA Rates.

16. Amounts shall be in U.S. dollars unless a specific percent is requested.

17. All active rates must be rounded to even cents.

18. Extension period rates are limited to the dollar amounts of the total benefit cost **AND** the "Maximum Benefit Cost Percent Increase from Prior Contract Period" filled out on the proposal sheets, excluding future premium changes related to changes in the benefit.

Important Self-Insured Proposal Instruction and Information

1. All Administrative fees must include all fees (except ACA fees which are listed separately) and taxes. Administrative fees shall exclude mandated ACA fees but include any administrative cost associated with existing or future federal or State requirements, including but not limited to ACA or IRA.

2. The EUTF reserves the right to offer multiple carrier options, except for a self-insured prescription drug plan which will be awarded to one OFFEROR for both active employees and retirees.

3. No adjustments to the proposed fees based on actual initial enrollment or subsequent enrollment changes are acceptable.

4. Fees must be quoted on a three-tiered basis (self, two-party, and family).

5. Fees must exclude commissions and payments made to any third party.

6. Fees must be filled out in the proposal sheets provided.

7. All fees must be guaranteed for the term of the contract including the proposed extensions (see Section 1.4, *Contract Period*).

8. Individual fee components will be assumed to be self-supporting standalone services.

9. All services to be provided for the quoted fee should be listed including quantities and frequencies.

10. Your fees must include any fee for PPO Leasing/Network Access for a national network to cover all 50 states, and the District of Columbia.

11. List services/supplies not covered under the fees quoted above (i.e., custom reports, printing, etc.).

12. Fees quoted are to cover services for claims incurred on or after the contract effective date. All fees for the payment of run-out claims must be included in the monthly fees charged during the contract period.

13. Amounts shall be in U.S. dollars unless a specific percent is requested.

6.6 MEDICAL PROVIDER NETWORK

Attach as Schedule 6, the provider network documents indicated below. The Contractor shall notify the EUTF at least 60 days in advance of any event (unless unforeseeable such as an act of God) or negotiation that may result in a provider network reduction where member disruption exceeds 10%. If such a change is not agreeable to the EUTF, the EUTF reserves the right to terminate the agreement without penalty with 90 days' notice.

1. Network. Complete the table below. Include an electronic list of all the providers in your provider network (i.e., PPO, HMO, Medicare Advantage) in the state by island and the number of providers that have physical offices on multiple islands. In addition, include a list of all the states where your provider network exists.

Provider Type	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai	Total
Acute Hospitals							
Urgent Care Facilities							
Outpatient Surgical Centers							
Clinics							
General/Family Practice Physicians							
OBGYN Specialists							
Other Specialists							

2. Disruption Analysis. As part of the proposal process, Segal will be conducting a member disruption analysis. Network data will be provided upon receipt of a signed Attachment 2, *Intent to Bid Form* and Attachment 3, *Confidentiality Agreem*ent. The utilized provider listing will be provided to assess the alignment between your provider networks and the participant utilization patterns.

   Please confirm whether the individual provider is currently a contracted network provider in each of your proposed networks. If, after award of the contract, the actual disruption proves to be greater than that identified in your response, the successful OFFEROR must provide accommodations to address the deviation.

   Geo Access. For each proposed network (i.e., PPO and HMO), provide a Geo Access report for each island in Hawaii and one report for all non-Hawaii residences, based upon the residential zip codes of the census file included with this RFP. Please make sure that the Geo Access reports match the total participant counts of the current census data provided in Section 4.9, *Plan Offerings*. For all providers in your network, list percent of participants by island and out-of-state with a minimum of 2 physicians within 8 miles of

the residential zip code and 1 hospital within 15 miles of the residential zip code.

6.7 PBM QUESTIONNAIRE

Attach as Schedule 7, Attachment 10, *PBM Questionnaire*. Provide responses as described in Section 6.4, *Medical Questionnaire*.

6.8 PBM PROPOSAL

Attach as Schedule 8, Attachment 11, *PBM Proposal*. The Important Self-Insured Proposal Instruction and Information listed in Section 6.5, *Plan Summaries and Fee Proposal*, apply. This includes that all fees must be guaranteed for the term of the contract including the proposed extensions.

Include a list of non-specialty and specialty products (with NDCs) that are excluded from your proposed drug pricing guarantees (discounts, dispensing fees, and/or rebates). Indicate whether the excluded product can be found in EUTF's claims data. Breakout the list by non-specialty products dispensed at retail 30, retail 90, and mail pharmacies and specialty products dispensed at retail 30, retail 90, and specialty pharmacies.

6.9 RETAIL PHARMACY NETWORK

Attach as Schedule 9, the retail pharmacy network documents indicated below for both commercial and EGWP.

1. Network. Complete the table below. Include a list of all the providers in your retail pharmacy network in the state by island. In addition, include a list of all the states where your provider network exists.

Provider Type	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai	Total
Retail 30							
Retail 90							

2. Disruption Analysis. As part of the proposal process, Segal will be conducting a member disruption analysis. Network data will be provided upon receipt of a signed Attachment 2, *Intent to Bid Form* and Attachment 3, *Confidentiality Agreem*ent. The utilized provider listing will be provided to assess the alignment between your provider networks and the participant utilization patterns.

   Please confirm whether the individual provider is currently a contracted network provider in each of your proposed networks. If, after award of the contract, the actual disruption proves to be greater than that identified in your response, the successful bidder must provide accommodations to address the deviation.

   Provide an Excel file that lists the specific retail pharmacies that will be negatively impacted (are considered out of network for the proposed retail 30 and/or the retail 90 network) along

with the total number of scripts and members impacted for each of these retail pharmacies should also be provided. For each proposed network, include the following:

a. Number of currently utilized retail pharmacies that are not part of the proposed network but are eligible to solicit
b. Number of members that are using those retail pharmacies that are not part of the proposed network but are eligible to solicit
c. Number of prescriptions adjudicated via those retail pharmacies that are not part of the proposed network but are eligible to solicit
d. Number of currently utilized retail pharmacies that are part of the proposed network
e. Number of members that are using those retail pharmacies that are part of the proposed network
f. Number of prescriptions adjudicated via those retail pharmacies that are part of the proposed network

OFFERORS are advised to offer improved pricing terms to the EUTF if more than 2% of utilizing members are impacted by proposed changes to the participating retail 30 and retail 90 pharmacy network.

3. Geo Access. For each proposed network, provide a Geo Access report for each island in Hawaii and one report for all non-Hawaii residences, based upon the residential zip codes of the census file included with this RFP. Please make sure that the Geo Access reports match the total participant counts of the current census data.

6.10 FORMULARY

Attach as Schedule 10, the formulary documents indicated below for both commercial and EGWP. Segal will be conducting a formulary disruption analysis based on your proposed formulary and the claims data provided upon submission of Attachment 3, *Confidentiality Agreement*.

1. Provide an Excel file for each of the following formularies (at the NDC level) being proposed:
    a. A non-specialty formulary (i.e., for preferred and non-preferred brand) for the commercial plans.
    b. A specialty formulary for the commercial plans.
    c. An alternative non-specialty formulary option for the commercial plans and the revised pricing for this option.*
    d. A Medicare Part D formulary.

    * OFFERORS will only be evaluated on the current EUTF formulary. However, OFFERORS may also provide pricing on an alternative non-specialty closed formulary. If OFFERORS offer multiple closed formularies, OFFERORS are advised to provide pricing on the least restrictive closed formulary. Proposals contingent on this alternative formulary will be rejected.

2. From the EUTF claims data provided for the prior 12 months, provide the top 10 brand drugs by cost that would move from preferred to non-preferred.

3. From the EUTF claims data provided for the prior 12 months, indicate what percent of generic drugs are currently considered preferred on your proposed formulary. If there are generic drugs considered non-preferred, explain and provide examples.

4. Provide an Excel file that lists the specific drugs that will be negatively impacted (higher cost tier) along with the number of utilizers and scripts for each drug. Provide a summary of your formulary disruption analysis using the table below:

Type of Change	Number of Utilizers	% of Total Utilizers	Number of Scripts	% of Total Scripts*
No change				
Positive change (moving to a lower cost tier)				
Negative change (moving to a higher cost tier)				
Change from covered to not covered				
Total		100%		100%

* Including all brand and generic scripts.

5. Provide an AWP-based NDC-11 pricing list in Excel of all specialty products, including limited distribution drugs, that your company has access to and indicate those your company does not have access to for your proposed specialty drug program. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:
    a. Product Name
    b. Therapeutic Group/Therapeutic Category
    c. NDC
    d. Guaranteed Minimum AWP Discount and Dispensing Fee for all specialty prescriptions
    e. Limited Drug Designation
    f. Biosimilar designation
    g. Access/No Access
    h. New to Market designation

6.11 DRUG UTILIZATION REVIEW AND TREND REPORT

Attach as Schedule 11, a sample Drug Utilization Review (DUR) and Trend report.

ATTACHMENTS AND EXHIBITS

ATTACHMENT 1: OFFER FORM, OF-1
ATTACHMENT 2: INTENT TO BID FORM
ATTACHMENT 3: CONFIDENTIALITY AGREEMENT
ATTACHMENT 4: CONFIDENTIAL INFORMATION
ATTACHMENT 5: EXCEPTIONS
ATTACHMENT 6: PERFORMANCE GUARANTEES
ATTACHMENT 7: OFFEROR INFORMATION SHEET
ATTACHMENT 8: MEDICAL QUESTIONNAIRE
ATTACHMENT 9: PLAN SUMMARIES AND FEE PROPOSAL
ATTACHMENT 10: PBM QUESTIONNAIRE
ATTACHMENT 11: PBM PROPOSAL
EXHIBIT A: CLAIMS EXPERIENCE
EXHIBIT B: PREMIUM RATES
EXHIBIT C: EUTF ADMINISTRATIVE RULES
EXHIBIT D: CONTRACT FORM AND GENERAL CONDITIONS
EXHIBIT E: EVIDENCE OF COVERAGE DOCUMENTS
EXHIBIT F: BUSINESS ASSOCIATE AGREEMENT
EXHIBIT G: SAMPLE 834 FILE
EXHIBIT H: CENSUS AND NETWORK DATA

ATTACHMENT 1

OFFER FORM, OF-1

STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)
RFP No. 24-001 Medical Benefits and Pharmacy Benefit Management Services

Procurement Officer
Department of Budget and Finance/EUTF
State of Hawaii
Honolulu, Hawaii 96813

Dear Procurement Officer:

The undersigned has carefully read and understands the terms and conditions specified in the Specifications and Special Provisions attached hereto, and in the General Conditions, by reference made a part hereof and available upon request; and hereby submits the following offer to perform the work specified herein, all in accordance with the true intent and meaning thereof. The undersigned further understands and agrees that by submitting this offer, 1) he/she is declaring his/her offer is not in violation of Chapter 84, Hawaii Revised Statutes, concerning prohibited State contracts, and 2) he/she is certifying that the price(s) submitted was (were) independently arrived at without collusion.

Offeror is:

☐ Sole Proprietor ☐ Partnership ☐ *Corporation ☐ Joint Venture
☐ Other _____
*State of incorporation: _____

Hawaii General Excise Tax License I.D. No. _____

Federal I.D. No. _____

Payment address (other than street address below): _____
City, State, Zip Code: _____

Business address (street address): _____
City, State, Zip Code: _____

Respectfully submitted:

Date	Authorized (Original) Signature
Telephone No.	Name and Title (Please Type or Print)
Fax No.	**Exact Legal Name of Company (Offeror)
E-mail Address	

**If Offeror is a "dba" or a "division" of a corporation, furnish the exact legal name of the corporation under which the awarded contract will be executed: _____

ATTACHMENT 2

INTENT TO BID FORM

RFP No. 24-001, Medical Benefits and Pharmacy Benefit Management Services

Email or fax this registration form by **October 19, 2023** to:

Mr. Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
Fax: (808) 586-2320
Email: eutf.rfp@hawaii.gov

Please be advised that we are in receipt of the above-referenced RFP. We also wish to advise that we will be submitting a proposal for the following service(s):

Attachment /Proposal Sheet #	**Plans**	**OFFEROR Proposing**
	ACTIVES	
9/1B & 11	☐ EUTF 90/10 PPO - Fully Insured (FI) Medical, Rx, and Chiro	☐ Yes ☐ No
9/1C	☐ EUTF 90/10 PPO - Self-Insured (SI) Medical and Chiro only	☐ Yes ☐ No
9/2B & 11	☐ EUTF 80/20 PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/2C	☐ EUTF 80/20 PPO - SI Medical and Chiro only	☐ Yes ☐ No
9/3B & 11	☐ EUTF 75/25 PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/3C	☐ EUTF 75/25 PPO - SI Medical and Chiro only	☐ Yes ☐ No
9/4B & 11	☐ EUTF Part-Time PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/5B & 11	☐ EUTF HMO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/5C	☐ EUTF HMO - SI Medical and Chiro only	☐ Yes ☐ No
9/6B	☐ EUTF Closed Panel Comprehensive HMO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/7B	☐ EUTF Closed Panel Standard HMO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/8B	☐ EUTF Closed Panel Part-Time HMO - FI Medical, Rx and Chiro	☐ Yes ☐ No
9/9B	☐ EUTF Supplemental Copay - FI Medical and Rx (no Chiro)	☐ Yes ☐ No
9/10B & 11	☐ HSTA VB 90/10 PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/10C	☐ HSTA VB 90/10 PPO - SI Medical and Chiro only	☐ Yes ☐ No
9/11B & 11	☐ HSTA VB 80/20 PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/11C	☐ HSTA VB 80/20 PPO - SI Medical and Chiro only	☐ Yes ☐ No
9/12B	☐ HSTA VB Closed Panel Comprehensive HMO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
11	☐ EUTF PPO & HMO - SI Rx only	☐ Yes ☐ No
11	☐ HSTA VB PPO - SI Rx only	☐ Yes ☐ No

RETIREES		
9/13B & 11	☐ EUTF 90/10 PPO - FI Medical and Rx (no Chiro)	☐ Yes ☐ No
9/13C	☐ EUTF 90/10 PPO - SI Medical only	☐ Yes ☐ No
9/14B	☐ EUTF Comprehensive HMO - FI Medical, Rx, and Chiro (no Chiro for Non-Medicare Retirees)	☐ Yes ☐ No
9/15B & 11	☐ EUTF Medicare Advantage LPPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/16B & 11	☐ HSTA VB 90/10 PPO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
9/16C	☐ HSTA VB 90/10 PPO - SI Medical and Chiro only	☐ Yes ☐ No
9/17B	☐ HSTA VB Comprehensive HMO - FI Medical, Rx, and Chiro	☐ Yes ☐ No
11	☐ EUTF PPO - SI Rx only	☐ Yes ☐ No
11	☐ EUTF EGWP - SI Rx only	☐ Yes ☐ No
11	☐ HSTA VB PPO - SI Rx only	☐ Yes ☐ No
11	☐ HSTA VB EGWP - SI Rx only	☐ Yes ☐ No

☐ Signed Confidentiality Agreement is attached.

A signed confidentiality agreement is required before census and network utilization data will be released. If the OFFEROR does not have a current agreement on file with Segal, one will be provided for signature before the census data and network utilization information will be released. Any request for changes to this agreement will require Segal's review and concurrence, which will delay the release of the census and network utilization information. If the OFFEROR already has a signed confidentiality agreement with Segal, please provide a copy of the agreement along with this Intent to Bid Form. **An intent to Bid Form and signed Confidentiality Agreement is not required to submit a proposal.**

Name of Company: _____

Primary Contact Name: _____

Primary Contact Phone: _____

Primary Contact Email: _____

Signature: _____

ATTACHMENT 3

CONFIDENTIALITY AGREEMENT
to be used by Entities Responding to RFPs

A signed confidentiality agreement is required before census and network utilization data will be released. If the OFFEROR does not have a current agreement on file with Segal, one will be provided for signature before the census data and network utilization information will be released. Any request for changes to this agreement will require Segal's review and concurrence, which will delay the release of the census and network utilization information. If the OFFEROR already has a signed confidentiality agreement with Segal, please provide a copy of the agreement along with the Intent to Bid Form (Attachment 2). **An Intent to Bid Form and signed Confidentiality Agreement are not required to submit a proposal.**

ATTACHMENT 4

CONFIDENTIAL INFORMATION

List all information believed to be confidential and not to be disclosed to the public. Identify the page numbers and sections in the proposal where the information is located.

_____

ATTACHMENT 5

EXCEPTIONS

Should OFFEROR take any exception to the terms, conditions, specifications, or other requirements listed in the RFP, OFFEROR shall list such exceptions in the space below. OFFEROR shall reference the RFP section where exception is taken, a description of the exception taken, and the proposed alternative, if any. The State reserves the right to accept or reject any request for exceptions.

_____

ATTACHMENT 6

PERFORMANCE GUARANTEES

All Medical Plans
Performance Guarantee Reporting

Performance Guarantees are not negotiable. Payments are calculated and paid quarterly based on the average enrollment of employees/retirees in the plan for the period in which the Performance Guarantee applies multiplied by the dollar amount per employee/per retiree (PE/PR) in each category, except where an annual measurement is indicated in which the average enrollment for the entire year would be used and payments are calculated and paid annually. Payments related to DM/IHM amounts measured and paid quarterly will be "trued-up" at year end. Performance Guarantees are subject to audit by the EUTF and are based on the combined performance under all contracts issued to the OFFEROR if more than one contract is issued to an OFFEROR.

The Contractor must document compliance with the Performance Guarantees in a sufficient manner for the EUTF's third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) to determine Contractor compliance with the Performance Guarantees. If the EUTF's third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) is unable to determine Contractor compliance because the documentation is insufficient, the Contractor will be deemed to have not complied with the Performance Guarantee for the applicable period.

Sampling or using non-EUTF specific data (e.g., utilizing Hawaii Regional data or National data) is not permitted in determining the measurements unless otherwise specified. **Rounding of measurements is not permitted for any Performance Guarantee in any situation**.

Each Performance Guarantee must be met in its entirety. If partially met, the full penalty amount for the category is owed. The following is an example of how the penalties are assessed:

Average enrollment during the period (e.g., quarter) is 10,000
Penalty for the category is $1.25 PE and PR
Contractor does not comply for 4 quarters
Penalty is $50,000 = 10,000 * $1.25 * 4 quarters

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Call Response Center				
1) 93.00% of calls answered within 20 seconds or 2) all calls answered within an average of 20 seconds (not including calls answered by an automated voice response system). The Contractor must select option 1 or 2 prior to commencement of the contract. This selection will remain in effect for the entire contract period.	Option 1: Number of calls answered within 20 seconds / total number of calls received Option 2: Total aggregate time from 1st ring to answer or abandonment / total number of calls received	Yes	Quarterly	$1.00

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
PPO, Open Panel HMO, and Supplemental: 98.00% of telephone inquiries/issues resolved at the first point of contact, as long as the Contractor's customer service representative has the information available at the time of the call. For inquiries requiring additional information or research, callers will be informed of the actions needed by the customer service representative and when the caller can expect resolution. Closed Panel HMO: 98.00% of telephone inquiries/issues resolved at the first point of contact.	The number of telephone inquiries/issues completely resolved at the first point of contact / (the total number of telephone inquiries/issues [for PPO, Open Panel HMO and Supplemental, less telephone inquiries/issues requiring additional information or research])	Yes	Quarterly	$1.00
Achieve call abandonment rate below 3.00%	Number of calls abandoned (callers hang up or are lost by the system) / total number of calls received	Yes	Quarterly	$1.00
Claims Processing and Claims Service				
Achieve 99.00% financial accuracy on claim payments. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims paid (in the sample) with the correct eligible charge less the correct member coinsurance / total number of claims for the quarter (in the sample)	Either	Quarterly	$1.00
Achieve 99.00% of claims coded accurately. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims (in the random sample) coded accurately / total number of claims for the quarter (in the random sample)	Either	Quarterly	$1.00
Process 99.00% of claims within 30 calendar days	Number of claims paid within 30 calendar days of receipt / total number of claims paid	Yes	Quarterly	$1.00
Process 99.00% of appeals within 30 calendar days of receipt of all supporting documentation for pre-service and 60 calendar days of receipt of all supporting documentation for post-service	Number of claims appeals (e.g., written letters that clearly state that it's an appeal and appeals filed under the Member Appeal Rights and Process) adjudicated (letter mailed approving or denying) within 30 calendar days for pre-service and 60 calendar days for post-service / total number of claims appeals. (Within 30 calendar days means if received on Thursday 8/1, letter mailed by Tuesday 9/3 4:30 p.m.)	Yes	Quarterly	$1.00
EUTF Trustee and EUTF Administrative Service				

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Resolve 98.00% of enrollee issues within 3 business days.	Resolved (i.e., items closed by EUTF) enrollment issues communicated by EUTF staff to Contractor (e.g., Administrator inquiry to the Contractor account team and rush enrollments) within 3 business days / total enrollment issues communicated by EUTF staff to Contractor. (Within 3 business days means if communicated on Monday 7/29 resolved by Thursday 8/1 4:30 p.m.)	Yes	Quarterly	$1.00
Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor service levels to the EUTF as rated by the EUTF on an annual basis.	EUTF to determine who will rate Contractor and weightings, and the criteria for the evaluation.	Yes	Annual	$2.00
Provide all reports (excluding Wellness and Total Health Management Reports noted below) as described in this RFP plus any additional reports requested by the EUTF within time periods determined by the EUTF staff.	Penalty will be prorated based on the number of missed report deadlines over the total report deadlines for the time period. (Monthly reports represent three reports for the quarter.) If the report provided on or after the deadline is incomplete (i.e., with missing sections), a penalty will be owed.	Yes	Quarterly	$2.50
Provide all benefit summaries/guides within time periods determined by the EUTF staff. Includes but is not limited to a summary of benefits and coverage (SBC) for active employee plans as required by ACA.	Penalty will be multiplied by the number of missed deadlines in the quarter.	Yes	Quarterly	$0.50
Maintain consistent, primary account team throughout the contract term unless a change is requested by the EUTF and mutually agreed to by the Contractor. Measurement of this guarantee will exclude replacement of primary account team members 1) due to termination of employment and 2) in cases of promotion or transfer out-of-state if the outgoing account team member's tenure overlaps with the incoming account team member's tenure for a period of at least one month (the "Transition Period") and the outgoing team member remains directly available to EUTF and the incoming account team member for inquiries and consultation for an additional period of at least one month after the Transition Period ends.	Primary account team members are indicated in the Contractor's response to the RFP and include the Account Manager, Senior Account Manager (supervisor of the Account Manager), Enrollment Manager, IT Manager, and Clinical Advisor. Refer to Section VI of this RFP.	Yes	Quarterly	$1.25

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Plan Administration				
Load weekly 834 files within 24 hours after delivery by EUTF and process all transactions (e.g., enrollments, terminations, and other life events) including mailing of ID cards within 48 hours	If the 834 file is electronically delivered Monday 7/29 10:00 a.m., all transactions must be loaded by Tuesday 7/30 10:00 a.m. and ID cards must be mailed by Thursday 8/1 10:00 a.m. If the 834 file is delivered Friday 8/2 10:00 a.m., all transactions must be loaded by Monday 8/5 10:00 a.m.	Yes	Quarterly	$1.00
Process 99.00% of all transactions accurately	Transactions from the 834 file processed accurately / total transactions from the 834 file. If there is a correction, it must occur within 24 hours after the 834 file is delivered by EUTF in order to be considered accurate.	Yes	Quarterly	$1.00
Achieve 99.00% accuracy on an annual reconciliation between the Contractor's enrollees versus the EUTF's enrollees, excluding enrollment differences due to timing.	Errors (e.g., EUTF has a member enrolled on their file, but the same member is not enrolled by the Contractor and vice versa not due to timing) / total enrolled by EUTF	Yes	Annual	$1.00
Maintain a Geo Access percentage of 95.00% or better than the results submitted in the proposal on a per island basis within the State and measured separately by providers, facilities and other sources of care and services. PPO and Open Panel HMO Geo Access percentages will be separately measured, and any penalties will be prorated based on subscribers.	PPO plan Geo Access and HMO plan Geo Access are based on the percentage of subscribers with a residential zip code where there is a minimum of two PCPs in an 8-mile radius and one acute hospital in a 15-mile radius. The PPO plan Geo Access and HMO plan Geo Access percentage standard of 95.00% are based on this updated Geo Access compared to the baseline for each island. Penalty will be multiplied by the subscriber count shortfall on each island where the PG is missed. By island: Number of EUTF PPO or HMO enrollees that fall within the above Geo Access parameters / total number of EUTF PPO or HMO plan enrollees	Yes	Quarterly	$2.00
Participant Service				

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Resolve 98.00% of written inquiries (including claims) within 10 business days and 100.00% within 20 business days of receipt	Number of written inquiries resolved within 10 business days (and 20 business days) / total number of written inquiries. (Within 10 business days means if received on Monday 7/29 resolved by Monday 8/12 4:30 p.m.)	Yes	Quarterly	$1.00
Achieve 90.00% satisfaction with the Contractor in an annual survey conducted by the Contractor based on an enrollee satisfaction survey. Contractor shall use random sampling with an error rate of 3.00% or less at a 95.00% confidence level.	Number of surveys completed with overall satisfaction with Contractor (e.g., satisfied, very satisfied or extremely satisfied) / total number of surveys completed	Yes	Annual	$2.00
Achieve 99.00% accuracy on communication to participants including ID cards. Letters are to be pre-approved by the EUTF prior to mailing.	Number of communication pieces that are accurate and sent to the correct participants (e.g., an individual letter to one EUTF member is one piece and one airing of a radio ad is one piece) / total number of communication pieces	Yes	Quarterly	$1.00
Wellness and Total Health Management				
Develop and present to EUTF, on or before 1/31/2026, a comprehensive wellness, disease management, integrated health management plan identifying areas for improvement in program utilization, lifestyle and health metrics. Include, at a minimum, trend and baseline data, measurable objectives, your strategies and interventions to meet objectives and a timeline for implementation. Monitor the plan and provide EUTF with an annual progress report, within 30 days after the end of the following calendar year.	Initial plan for actives and retirees due on or before 1/31/2026.	Yes	Initial Plan (One-time) Plan Monitoring (Annual)	1% of annual DM/IHM fees (initial plan and monitoring)
Report on Healthcare Effectiveness Data and Information Set (HEDIS) measures including but not limited to cancer screenings, respiratory conditions, cardiovascular conditions and comprehensive diabetes care. Provide a final report annually by November 30, covering the period from January 1 - December 31.	Contact EUTF for a report template outlining data and information to include in the annual report and summary presentation. Data elements will include, but not be limited to, a 3-year trend comparing EUTF rates by member type, and unions to regional averages, industry averages and HEDIS national 90th percentile in PPT format.	Yes	Annual	2% of annual DM/IHM fees

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Report utilization rates and recommendations for improvements for wellness, disease management and integrated health management programs by member type, within 30 days after the end of each quarter. This includes all delegates.	EUTF to determine content, scope of reports, and due dates.	Yes	Annual	2% of annual DM/IHM fees
For both the commercial and retiree populations, meet or exceed the national 90th percentile quality benchmark; or show improvement of 5.00% or better from the prior year in the diabetes test result percentage for A1c levels less than or equal to 8.0.	See column 1 for description.	Yes	Annual	2% of annual DM/IHM fees
For both the commercial and retiree populations, meet or exceed the national 90th percentile quality benchmarks; or show improvement of 5.00% or better from the prior year in hypertension control <140/90.	See column 1 for description	Yes	Annual	2% of annual DM/IHM fees
Report on the burden of disease including prevalence data for lifestyle and chronic conditions; and the contributing cost of chronic conditions. Provide a final report annually, by July 31, covering the period January 1 – December 31.	Contact EUTF for a report template outlining data and information to include in the annual report and summary presentation. Data elements will include, but not be limited to, a 3-year trend comparing EUTF rates by member type, and unions to regional averages, industry averages, state book of business in PPT format.	Yes	Annual	2% of annual DM/IHM fees
This percentage of members targeted for case management will either be successfully contacted or will receive a minimum of two outreach attempts. The percentage of members targeted will be mutually agreed upon between the EUTF staff and the Contractor. This applies to all lines of business and case management programs at an aggregate level. At the same time, at least 50% of members successfully contacted will enroll in a case management program.	Year 1: 20% of targeted members are either successfully contacted or receive at least two contact attempts Year 2: 25% of targeted members are either successfully contacted or receive at least two contact attempts Year 3: 30% of targeted members are either successfully contacted or receive at least two contact attempts Year 4: 35% of targeted members are either successfully contacted or receive at least two contact attempts	Yes	Annual	2% of annual DM/IHM fees
Member Satisfaction: 85% of members who complete the satisfaction survey will indicate they are satisfied or highly satisfied with the overall service they received from the case management programs.	Measurement levels defining satisfied and highly satisfied will be mutually agreed upon	Yes	Annual	2% of annual DM/IHM fees

PBM Services
Performance Guarantee Reporting

Performance Guarantees are not negotiable. Payments are calculated and paid quarterly based on the average enrollment of employees/retirees in the plan for the period in which the Performance Guarantee applies multiplied by the dollar amount per employee/per retiree (PE/PR) in each category, except where an annual measurement is indicated in which the average enrollment for the entire year would be used and payments are calculated and paid annually. Performance Guarantees are subject to audit by the EUTF and are based on the combined performance under all contracts issued to the OFFEROR if more than one contract is issued to an OFFEROR.

The Contractor must document compliance with the Performance Guarantees in a sufficient manner for the EUTF's third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) to determine Contractor compliance with the Performance Guarantees. If the EUTF's third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) is unable to determine Contractor compliance because the documentation is insufficient, the Contractor will be deemed to have not complied with the Performance Guarantee for the applicable period.

Sampling or using non-EUTF specific data (e.g., utilizing Hawaii Regional data or National data) is not permitted in determining the measurements unless otherwise specified. **Rounding of measurements is not permitted for any Performance Guarantee in any situation**.

Each Performance Guarantee must be met in its entirety. If partially met, the full penalty amount for the category is owed. The following is an example of how the penalties are assessed:

Average enrollment during the period (e.g., quarter) is 10,000
Penalty for the category is $1.25 PE and PR
Contractor does not comply for 4 quarters
Penalty is $50,000 = 10,000 * $1.25 * 4 quarters

IMPLEMENTATION GUARANTEES

The EUTF will require specific implementation guarantees. The categories/standards below are pass/fail categories/standards, and failure in any part of a category/standard requires the total payment for that category.

Implementation Guarantees	Standard	Annual Per Year Penalty Dollars at Risk
Implementation Team	Implementation team will be assigned and introduced to EUTF at least 6 months in advance of effective date. Implementation team will not change, unless requested by EUTF.	$150,000.00
Timely and Accurate Installation	Installation of all administrative, clinical and financial parameters for EUTF's program will be completed by November 1, 2024 and will involve no systems errors. ID cards will be delivered within 14 days of receipt of final file from EUTF. EUTF and members have access to all online tools by October 1, 2024.	$300,000.00
Implementation Satisfaction Scorecard	Assigned Account Executive will work with EUTF prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to client after implementation is completed. EUTF Administrator will complete scorecard after implementation. Any overall score less than satisfactory will result in full payment for this category.	$300,000.00

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Payment Accuracy and System Performance				
Financial Accuracy – Achieve 99.00% financial accuracy on claim payments. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims paid (in the random sample) with the correct eligible charge less the correct member coinsurance / total number of claims for the quarter (in the random sample)	Yes	Quarterly	$0.15
Mail Service Non-Financial Accuracy – 99.00% dispensing accuracy of the mail service pharmacy across all EUTF lines of business (e.g., correct participant name, correct participant address, correct drug, correct dosage form, correct strength).	The number of errors / total number of mail service prescriptions dispensed in the quarter	Yes	Quarterly	$0.15

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
System Downtime – 98.50% of the time pharmacies in PBM's network shall have access to its network 24 hours a day, 7 days a week, 365 days a year.	Minutes of downtime including normal scheduled maintenance / total number of minutes in the quarter	No	Quarterly	$0.10
Eligibility Data – Load weekly clean 834 files within 24 hours after delivery by EUTF and process all transactions (e.g., enrollments, terminations, and other life events). "Clean" is defined as records that contain the mutually agreed upon data elements and the file processes in its entirety and does not suspend. Contractor will mail 100.00% of the ID cards within 4 business days (within 10 business days for the EGWP) after file load completion if the file is loaded electronically.	If the 834 file is electronically delivered Monday 7/29 10:00 a.m., all transactions must be loaded by Tuesday 7/30 10:00 a.m. and ID cards must be mailed by Monday 8/5 4:30 p.m. (Tuesday 8/13 4:30 p.m. for EGWP). If the 834 file is delivered Friday 8/2 10:00 a.m., all transactions must be loaded by Monday 8/5 10:00 a.m.	Yes	Quarterly	$0.15
Eligibility Data Accuracy – Process 99.00% of all transactions accurately.	Transactions from the 834 file processed accurately / total transactions from the 834 file. If there is a correction, it must occur within 24 hours after the 834 file is delivered by EUTF in order to be considered accurate.	Yes	Quarterly	$0.15
Eligibility Data Error Reporting – Eligibility file error reporting on all electronic eligibility file updates will be provided to the EUTF within 2 business days after delivery of the 834 file by EUTF.	Penalty will be multiplied by the number of error reports not received within 2 business days after delivery of the 834 file during the quarter.	Yes	Quarterly	$0.15
Invoicing Errors – All invoicing errors (e.g., service warranties) will be credits back to the client within two months of identification of the error.	Penalty will be multiplied by the number of invoicing errors not credited back within 2 months during the quarter. If an error was identified on 3/1 and was not credited back to EUTF by 5/1, a penalty will be owed for the 2nd quarter. A penalty will be owed for each quarter thereafter until credited back to EUTF.	Yes	Quarterly	$0.10
Enrollment Accuracy – Achieve 99.00% accuracy on an annual reconciliation between the Contractor's enrollees versus the EUTF's enrollees, excluding enrollment differences due to timing.	Errors (e.g., EUTF has a member enrolled on their file, but the same member is not enrolled by the Contractor and vice versa, not due to timing) / total enrolled by EUTF	Yes	Annual	$0.15
Account Management				

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Client Approval of Enrollee Communications – Achieve 99.00% accuracy on communication to participants including ID cards. Letters are to be pre-approved by the EUTF prior to mailing.	Number of communication pieces that are accurate and sent to the correct participants (e.g., an individual letter to one EUTF member is one piece and one airing of a radio ad is one piece) / total number of communication pieces	Yes	Quarterly	$0.10
Delivery of Reports – Provide all reports as described in this RFP plus any additional reports requested by the EUTF within time periods determined by the EUTF staff.	Penalty will be prorated based on the number of missed report deadlines over the total report deadlines for the time period. (Monthly reports represent three reports for the quarter.) If the report provided on or after the deadline is incomplete (i.e., with missing sections), a penalty will be owed.	Yes	Quarterly	$0.50
Delivery of Benefit Summaries – Provide all benefit summaries within time periods determined by the EUTF staff. Includes but is not limited to a summary of benefits and coverage (SBC) for active employee plans as required by ACA.	Penalty will be multiplied by the number of missed deadlines in the quarter.	Yes	Quarterly	$0.10
Pharmacy Audit Resolution – Contractor guarantees credits resulting from Pharmacy Desk Top Audits will be applied to the EUTF's invoice within 45 days of resolution.	Penalty will be multiplied by the number of credits not applied within 45 days of resolution during the quarter.	Yes	Quarterly	$0.10
Account Team Performance – Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor service levels to the EUTF as rated by the EUTF on an annual basis.	EUTF to determine who will rate the Contractor and weightings, and the criteria for the evaluation.	Yes	Annual	$1.50

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Account Team Turnover – Maintain consistent, primary account team throughout the contract term unless a change is requested by the EUTF and mutually agreed to by the Contractor. Measurement of this guarantee will exclude replacement of primary account team members 1) due to termination of employment and 2) in cases of promotion or transfer out-of-state if the outgoing account team member's tenure overlaps with the incoming account team member's tenure for a period of at least one month (the "Transition Period") and the outgoing team member remains directly available to EUTF and the incoming account team member for inquiries and consultation for a further period of at least one month after the Transition Period ends.	Primary account team members are indicated in the Contractor's response to the RFP and include the Account Manager, Senior Account Manager (supervisor of Account Manager), Enrollment Manager, IT Manager, and Clinical Pharmacist. Refer to Section VI of this RFP.	Yes	Quarterly	$0.25
Maintenance of Network – Maintain a Geo Access percentage of 95.00% or better than the results submitted in the proposal on a per island basis within the State.	Geo Access is based on the percentage of in-network pharmacies within a 15-mile radius of member residences. The Geo Access percentage standard of 95.00% is based on this updated Geo Access compared to the baseline for each island. Penalty will be multiplied by the subscriber count shortfall on each island where the PG is missed. By island: Number of in-network pharmacies that fall within the above Geo Access parameters / total number of in-network pharmacies	Yes	Quarterly	$1.00
Member Services				
Mail Turnaround–Prescriptions not requiring intervention – all prescriptions dispensed within an average of 2 business days from receipt.	Total business days to dispense prescriptions from receipt / total number of prescriptions dispensed	Yes	Quarterly	$0.10
Mail Turnaround – Prescriptions requiring intervention – all prescriptions requiring intervention dispensed within an average of 5 business days from receipt.	Total business days to dispense prescriptions from receipt / total number of prescriptions requiring intervention dispensed	Yes	Quarterly	$0.10

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Mailing Enrollee Materials – 100% of enrollee materials will be mailed at least 10 business days prior to the effective date and will be 100.00% accurate (provided that eligibility file was received at least 30 days prior to the effective date).	Number of communication pieces that are mailed at least 10 business days prior to the effective date and 100% accurate / total number of communication pieces	Yes	Quarterly	$0.10
Phone Speed of Answer – 1) 93.00% of calls answered within 20 seconds or 2) all calls answered within an average of 20 seconds (not including calls answered by an automated voice response system). The Contractor must select option 1 or 2 prior to commencement of the contract. This selection will remain in effect for the entire contract period.	Option 1: Number of calls answered within 20 seconds / total number of calls received. Option 2: Total aggregate time from 1st ring to answer or abandonment / total number of calls received	Yes	Quarterly	$0.10
Phone Abandonment Rate – Achieve call abandonment rate below 3.00%.	Number of calls abandoned (callers hang up or are lost by the system) / total number of calls received	Yes	Quarterly	$0.10
Written Inquiry Answer Time – Resolve 98.00% of written inquiries (including claims) within 10 business days and 100.00% resolved within 20 business days of receipt.	Number of written inquiries resolved within 10 business days (and 20 business days) / total number of written inquiries. (Within 10 business days means if received on Monday 7/29 resolved by Monday 8/12 4:30 p.m.)	Yes	Quarterly	$0.10
Enrollees Satisfaction Survey – Achieve 90.00% satisfaction with the Contractor in an annual survey conducted by the Contractor based on an enrollee satisfaction survey. Contractor shall use random sampling with an error rate of 3% or less at a 95% confidence level.	Number of surveys completed with overall satisfaction with Contractor (e.g., satisfied, very satisfied or extremely satisfied) / total number of surveys completed	Yes	Annual	$1.00
Issue Resolution: Verbal Inquiries – 98.00% of telephone inquiries/issues resolved at the first point of contact.	The number of telephone inquiries/issues completely resolved at the first point of contact / the total number of telephone inquiries/issues	Yes	Quarterly	$0.10
Issue Resolution – Resolve 98.00% of enrollee issues within 3 business days.	Number of enrollee issues resolved within 3 business days / total number of enrollee issues	Yes	Quarterly	$0.10

ATTACHMENT 7

OFFEROR INFORMATION SHEET

Offeror Information	
Organization Name	
Parent Company Name (if any)	
Year Established	
Contact Name	
Title	
Address	
Phone Number	
Email	
Fax Number	

Membership Counts			
	2020	**2021**	**2022**
Medical			
National PPO			
Hawaii PPO			
National HMO			
Hawaii HMO			
Prescription Drug			
National			
Hawaii			

Group Client Retention Rates (%)			
	2020	**2021**	**2022**
Medical			
Fully Insured Plans			
Self-Insured Plans			
Prescription Drug			
Fully Insured Plans			
Self-Insured Plans			

Group Client Termination Rates (%)			
	2020	**2021**	**2022**
Medical			
Fully Insured Plans			
Self-Insured Plans			
Prescription Drug			
Fully Insured Plans			
Self-Insured Plans			

Client References	
Client #1	
Client Name	
Contact Name	
Phone Number	
Email	
Address	
Number of Employees Covered	
Number of Retirees Covered	
Contract Start Date	
Client #2	
Client Name	
Contact Name	
Phone Number	
Email	
Address	
Number of Employees Covered	
Number of Retirees Covered	
Contract Start Date	
Client #3	
Client Name	
Contact Name	
Phone Number	
Email	
Address	
Number of Employees Covered	
Number of Retirees Covered	
Contract Termination Date and Reason	

ATTACHMENT 8

MEDICAL QUESTIONNAIRE

	Question	Offeror Response
A	**GENERAL INFORMATION**	**Yes / No**
1.	Do you agree that if this proposal results in your company being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in the Proposal Response that any controversy arising over such discrepancy will be resolved in favor of the language contained in the RFP, unless specifically modified by the contract (Y/N)?	
	If No, explain here-1.	
2.	Do you agree to be bound by the terms of the RFP and your proposal until a final contract is executed (Y/N)?	
	If No, explain here-2.	
3.	Are there any Special Conditions outlined in Section 1.29 that you cannot meet (Y/N)? If yes, explain.	
	If Yes, explain here-3.	
4.	Do you agree to perform all of the services contained in this RFP (including Section IV, Scope of Work), except those specified in Attachment 5, Exceptions (Y/N)?	
	If No, explain here-4.	
5.	Are all deviations from the requested plan design and coverage included in the tables in Attachment 9, Plan Summaries and Fee Proposal (Y/N)?	
	If No, explain here-5.	
6.	Does your company, including any affiliates, subsidiaries, or principals of the company, have any pending or has had any legal actions against the State of Hawaii, the EUTF Board, or any EUTF Trustee within the last five years (Y/N)? If yes, explain.	
	If Yes, explain here-6.	
7.	Do you agree to provide written notification of renewal actions 240 days preceding the expiration of the contract (Y/N)?	
	If No, explain here-7.	

	Question	Offeror Response
B	**ORGANIZATION DESCRIPTION**	
8.	In the past 24 months, has your organization acquired, been acquired by, or merged with another organization (Y/N)?	
	If yes, explain.	

	Question	Offeror Response
9.	Is your organization anticipating undertaking any mergers, acquisitions, sell-offs, or change of ownership (Y/N)?	
	If yes, explain.	
10.	In the past 24 months, has your organization restructured or made any major changes to your organization such as outsourcing, staff relocations, member service or claims office closings, or change in computer or phone systems (Y/N)?	
	If yes, explain.	
11.	Is your organization anticipating restructuring or making any major changes to your organization such as outsourcing, staff relocations, member service or claims office closings, or change in computer or phone systems (Y/N)?	
	If yes, explain.	
C	**ADMINISTRATIVE SERVICES**	
	Account Services	
12.	Do you offer any services with respect to reporting requirements under ACA (Y/N)?	
	If yes, what services do you offer?	
	Confirm that these services will be provided at no additional cost.	
13.	Of the services listed below, which services are included in the basic fee? List all that apply. Confirm that these services will be provided at no additional cost. a. SPDs and SBCs b. Claim Forms c. EOBs d. Network Directory e. Other	
14.	What online services will be made available to EUTF staff? List all that apply. a. Claims Summary b. Billing History c. Premium Rates d. Provider Directory e. Eligibility Summary f. Enrollment Counts g. Plan Details/Benefit Summary (including integrated prescription drug and chiropractic benefit information) h. Health Topics/Medical Information i. Address Changes j. Dummy login to the member portal that can be used throughout the term of the contract	

	Question	Offeror Response
	k. Other	
	Provide a sample website, login and password if applicable.	
15.	What online services will be made available to EUTF members? List all that apply. a. Claims Summary/EOB b. Billing History c. Premium Rates d. Provider Directory e. Enrollment Summary f. Plan Details/Benefit Summary (including integrated prescription drug and chiropractic benefit information) g. Health Topics/Medical Information h. Address Changes i. Clinical resources/actionable items to enhance care for patients with chronic and complex conditions j. Other (including lab results, referrals, prior authorization requests, and prescriptions)	
	Provide a sample website, login and password if applicable.	
16.	Is there a mobile app available for members to access online services?	
17.	Do you offer a 24-hour Nurse Triage phone line or Online Medical Care (physician or nurse advice/demand management) for enrollees (Y/N)? If yes, confirm that these services will be provided at no additional cost.	
18.	Do you agree to cover all eligible expenses incurred by a covered participant who is hospitalized on the date of termination until that person is discharged from the hospital (Y/N)?	
19.	How are services provided for members who are travelling domestically or internationally? For an extended period of time (e.g. visiting semester)? For non-Medicare eligible members? For Medicare eligible members?	
20.	Does your proposal include any allowances or credits for the EUTF to use at their discretion? Please provide the amounts available for each type of service (implementation, communications, etc.) and the time period in which they must be used.	
	Audit Requirements	
21.	Do you agree to allow the EUTF the right to audit the performance of the plan and	

	Question	Offeror Response
	services provided as described in Section 4.19, Audit Requirements (Y/N)? If yes, indicate what services, records and access will be provided at no additional cost.	
22.	Do you agree to an independent annual audit that measures performance through random sampling (Y/N)? Attach a copy of your audit policy to your proposal.	
23.	Do you agree to provide a comprehensive data file to the auditor that will facilitate electronic analysis with target samples validated through the auditor's review of supporting documentation of sufficient sample size to meet the auditor's requirements to achieve the level of confidence determined by the auditor (Y/N)?	
24.	Confirm your understanding that results from an independent random claims sample will determine compliance with processing performance guarantees.	
25.	Confirm your understanding that non-processing performance guarantees may be validated through an independent audit with such results determining the amount of any penalty due.	
26.	Are you willing to pay an additional penalty amount if the auditor deems there was an error in the self-reported performance guarantee results (Y/N)? If yes, indicate amount.	
	Claims Processing	
27.	Provide the following regarding the claims offices used:	
	a. Location	
	b. Average Claims/Processor/Day	
	c. Annual Claim Volume	
	d. Claim denial rate percentage	
	e. Percentage of denied claims overturned on appeal	
	f. Provide number of: • Processors • Supervisors • Managers	
	g. Average years of claims administration experience for: • Processors • Supervisors • Managers	
	h. Annual turnover percent (%): • Processors • Supervisors	

	Question	Offeror Response
	• Managers	
28.	Provide the following claim turnaround time information based on the latest 12-month period:	
	a. Average number of business days to process a claim from date received to date check/EOB issued	
	b. Percent of all claims submitted processed (from date received to date check/EOB issued) within 10 business days	
	c. Percent of all claims submitted processed (from date received to date check/EOB issued) within 30 business days	
	d. Have you been penalized by any state for failing to meet state average claim turnaround requirements in the last 12 months (Y/N)? If yes, indicate which states.	
29.	Provide the following claims processing accuracy information based on the latest 12-month period:	
	a. Financial accuracy as a percent of total claims dollars paid (include over/underpayments)	
	b. Coding accuracy (claims without error) as a percent of total claims submitted	
30.	Describe your COB procedures.	
	a. Does COB occur prospectively or retrospectively to payments?	
	b. How often are records updated for new information on other coverage?	
	c. What is the average COB savings as a percent of total plan cost for: • Active/Early retiree • Medicare Eligible	
	d. Will you guarantee COB savings for: • Active/Early retiree • Medicare Eligible	
31.	When you are the secondary payor in a COB situation, do you use your UCR profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?	
32.	Describe your appeals process. Include turnaround time to notify member of appeal determination.	
33.	Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. If the process is different for in-network and out-of-network claims, describe separately.	

	Question	Offeror Response
	For example, do you batch process checks to network providers? If so, explain.	
34.	How do you reimburse multiple surgical procedures being performed during one operation? Is a reduced scale used for the first and subsequent procedures (Y/N)?	
35.	Describe your procedures for recovery of overpayments or duplicate payments. Do you agree to return all recovered monies from overpayments or duplicate payments to client (Y/N)? If no, explain.	
	Enrollment	
36.	Do you agree to receive and timely and accurately process all of the enrollment and eligibility information in the format as provided by EUTF, without the EUTF making changes to its file format (Y/N)? See Exhibit G, *Sample 834 File*.	
	Fraud Detection Program	
37.	Describe your fraud detection program. Include how members are notified of the fraud identified and the resolution process. If there is a formal written program, attach a copy to your proposal.	
38.	Include the following information on your fraud detection program (per 1,000 covered lives) for CY 2022: a. Total number of fraud cases b. Total number of ineligible claimants c. Error rate in services billed (%) d. Total number of over billings	
39.	Do you monitor individual physician prescribing patterns (Y/N)? If yes, what action is taken with prescribers who have a high degree of non-compliance or outlier prescribing?	
40.	Do you retain medical consultants for the review of any unusual claims or charges (Y/N)? If yes, explain the method in which such consultants are used and describe their qualifications and any affiliations.	
	HIPAA Requirements	
41.	Do you have a formal HIPAA compliance plan in place (Y/N)? If yes, attach a copy to your proposal.	
42.	Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions (Y/N)?	

	Question	Offeror Response
	If yes, provide the website.	
43.	Where does the copy of your Companion Guide for HIPAA EDI transactions reside?	
44.	Will a Notice of Privacy Practices be issued to each new plan enrollee as required by HIPAA (Y/N)? Confirm that these notices will be provided at no additional cost.	
D	**CUSTOMER SERVICES**	
	Call and Walk-in Centers	
45.	Provide the following information regarding your local call center for CY 2022:	
	a. Location	
	b. Number of staff	
	c. Days and hours of operation	
	d. Percent of calls abandoned	
	e. Percent of calls handled by a live representative within 20 seconds	
	f. Average number of seconds to reach a live representative	
	g. Number of inquiries made to the call center	
46.	Provide the location of your walk-in center and number of staff.	
47.	Will dedicated customer service representatives be assigned to this account (Y/N)? If yes, how many at the call center and at the walk-in customer service center?	
48.	Do customer service representatives have online access to real-time claim status information (Y/N)?	
49.	How does your organization accommodate enrollees with special needs? List all that apply. a. No special accommodations b. TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing-impaired c. Contracted independent translation company to accommodate non-English speaking enrollees d. Customer service staff with the ability to translate multiple languages (indicate which languages) e. Other	
	Member Satisfaction	
50.	How are member complaints tracked?	
51.	List the top 5 member complaints. What processes/remedies were put in place to resolve these complaints?	

	Question	Offeror Response
52.	Do you currently perform member satisfaction surveys? If yes, what percent of members indicated that they were "satisfied" or "very satisfied" with overall plan services? What percent of members indicated that they were "dissatisfied" or "very dissatisfied" with overall plan services?	
53.	Will you survey EUTF members annually to measure enrollee satisfaction as required by Attachment 6, *Performance Guarantees*, at no additional cost (Y/N)?	
E	**UNDERWRITING ISSUES – FULLY INSURED PLANS**	
54.	a. Explain the methodology and data to be used for the renewal process. How will projected incurred claims be estimated for these plans?	
	b. What experience period(s) will be used for the first renewal?	
	c. What credibility will be given to each period of experience used?	
55.	Explain your methodology for establishing Incurred But Not Reported (IBNR) reserve?	
56.	Indicate the factors used to set the rates for the proposal.	
	Annual Trend Factor __% of expected claims	
	Reserve Factor __% of expected claims	
	Margin ____% of expected claims	
57.	Explain any other required reserves other than for IBNR. Indicate amounts, reason for reserve, whether interest is credited, and whether reserves are refunded to the client upon policy termination.	
58.	Detail any underwriting provisions/rules you will impose on the EUTF.	
F	**DISEASE MANAGEMENT / INTEGRATED HEALTH MANAGEMENT (DM/IHM)**	
59.	Do you perform DM/IHM services (Y/N)? If yes, describe the services covered by your basic fee. For each program service, include program name, a description of the program, condition(s) managed, stratification levels, member identification process, program goals, interventions, and performance metrics.	
60.	Do you have a minimum of three years of experience in performing these services? Provide years of experience for each program listed in No. 1 above.	

	Question	Offeror Response
61.	Are you currently providing DM/IHM services to a group of at least 30,000 covered members (Y/N)? If yes, list group names.	
62.	Do you have the ability and are you willing to customize your DM/IHM services to meet the needs/desires of the EUTF? Describe limitations if any.	
63.	Do you have the capability to identify specific members targeted for these DM/IHM services (e.g., retirees vs. actives)?	
64.	Do you agree to provide EUTF specific data reports of DM/IHM activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within 3 months of the close of the prior year? Will these reports include engagement and outcomes for services delegated to outside entities?	
65.	Do you agree (that after the award of this contract and during the implementation phase of your services) to mine the EUTF medical claims and prescription drug data and identify those individuals appropriate for DM/IHM services AND provide the EUTF (prior to the start date of the contract) with a report that outlines what you found in their data, including but not limited to the following elements:	
	a. The total number of members identified with one or more chronic diseases you will manage in the initial data analysis by specific DM/IHM program service	
	b. The number of members you identified in each of your risk classes/level	
	c. The costs associated with the above groups	
	d. The percent of clinical goals/objectives the population is not adhering to in the baseline data search	
	e. A comparison of the EUTF's performance to HEDIS 90th percentile benchmark and "book of business" outcomes for similar sized clients of the same or similar industry	
66.	Which of your DM/IHM program(s) focus on helping members identify and lessen the following disease conditions and risk factors: a. Obesity b. Smoking c. High cholesterol d. Lack of activity/exercise e. Stress Management f. Diabetes g. Asthma	

	Question	Offeror Response
	h. Chronic obstructive pulmonary disease i. High blood pressure j. Ischemic heart disease k. Congestive heart failure	
67.	Are your DM/IHM services available to be used by participants who live in any of the 50 states?	
68.	Describe in detail your methods and strategies to engage members, both retirees and actives, to participate in DM/IHM programs. If you partner with delegates to provide any DM/IHM services, include a description of any deviations from your methods and strategies for the delegated entities.	
69.	How do you recommend that a client communicate and encourage the use of these services among retirees and active members?	
70.	Describe your expected rates in DM/IHM programs for the following stages: a. The percentage of members your programs will target for DM/IHM b. The percentage of targeted members you will outreach each year c. The percentage of outreached members you will successfully contact each year d. The percentage of contacted members who will participate in DM/IHM programs each year	
71.	Based on data, what DM/IHM programs have been the most effective to improve the health condition of members with chronic conditions?	
72.	Explain how your staff introduces themselves to members for the first time for DM/IHM programs (e.g. phone call, letter)?	
73.	What DM/IHM programs are available at an additional cost? Explain in detail and include the additional cost.	
74.	Do you have a claims-based diabetes management program (Y/N)? If yes, describe. Include eligibility criteria, engagement strategy, funding mechanism, member cost share, Geo Access, health coaching, PCP collaboration, performance guarantees, and proven outcomes/ROI. If not, are you willing to implement such a program within a year of the contract start date?	

	Question	Offeror Response
75.	Do you have a claims-based weight loss program (Y/N)? If yes, describe. Include eligibility criteria, engagement strategy, funding mechanism, member cost share, Geo Access, health coaching, PCP collaboration, performance guarantees, and proven outcomes/ROI. If not, are you willing to implement such a program within a year of the contract start date?	
76.	What percentage of members are engaged for DM/IHM services? An engaged member should be any member who has received outreach from you.	
G	**WELLNESS PROGRAMS**	
77.	Describe your wellness program. List all components of your wellness program (e.g. health risk survey, health coaching, health education classes, fitness program). For each component describe: a. The intervention b. Risk factors the program addresses (e.g. obesity, poor nutrition, lack of physical activity, smoking, high blood pressure, high blood cholesterol, medication adherence) c. Program goals d. Format offered (face-to-face, telephonic, online, etc.) e. Setting (e.g. worksite, other) f. Target member population (retirees and/or actives) g. How you measure the effectiveness of the program and its individual components.	
78.	Do you have a minimum of three years of experience in delivering wellness program services? Provide years of experience for each program component listed in No. 1 above.	
79.	Describe implemented strategies and methods to engage participation in the wellness program components described above for the active and retiree population.	
80.	For each service listed and/or requested, provide expected participation (based on a percent of total eligible members).	
81.	Describe factors to improve participation for both active and retiree members.	
82.	Describe factors that will reduce participation?	

	Question	Offeror Response
83.	Based on the demographics list the wellness program components you would expect to have the greatest impact on the following listed from highest to lowest impact: a. Reducing medical plan costs b. Increase productivity c. Member satisfaction and acceptance	
84.	Describe your capacity to report wellness program activity by member type (retiree and/or active) and by employer.	
85.	Do you agree to provide EUTF specific data reports of wellness program/IHM utilization activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within three months of the close of the prior year?	
86.	Based on your prior experience with wellness programs, for the program components listed above, provide the expected dollar savings per eligible member per year? Indicate expected savings by: a. Reduction in medical plan costs b. Reduction in lost workdays c. Increases in productivity. d. Other factors you can identity	
87.	What is the method used in the derivation of savings estimate provided in No. 86 above.	
88.	For each program implemented what is the expected ratio of savings to program expenses in the first 12 months, 24 months and 36 months?	
89.	What is done to assess plan participant satisfaction with the program? Are management reports available? If so, please include a sample(s).	
90.	Explain in detail each wellness program component included in your quote. What wellness programs are available at an additional cost? Explain in detail and include additional cost.	
91.	Provide a full explanation of how your company reimburses providers in order to control cost and manage utilization, other than fee for service arrangements.	
92.	Explain what programs you have implemented that address progress toward achieving patient centered outcome measurement and reimbursement to providers that improve these outcomes.	
93.	Describe current Performance Improvement Projects (PIPs) with providers. If none, can your company undertake a PIP with providers that are to achieve, through	

	Question	Offeror Response
	ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction? The PIPs shall include the following: • The use of objective, measurable, and clearly defined quality indicators to measure performance; • Valid sampling techniques; • Accurate and complete data collection; • The implementation of appropriate planned system interventions to achieve improvement in quality; • An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis; • An achievement of real improvement that is sustained; and • A plan and activities that shall increase or sustain improvement.	
94.	Are all the PIP services included in your base quote? If not, indicate the changes on a per capita basis.	
95.	Describe methods to identify members with pre-diabetes and programs to address this member population.	
96.	Does your proposal include any allowances or credits for the EUTF to use at their discretion? Please provide the amount available for wellness programs and the time period in which they must be used.	
H	**NETWORK MANAGEMENT**	
	Provider Directory	
97.	Indicate what is included in your provider directory. List all that apply. a. Physician office address and phone number b. Specialty designation (e.g., cardiology, pediatrics, urgent care) c. Doctor accepting new patients d. Office hours e. Languages spoken in office f. List of hospital with admitting privileges	
98.	How often is the provider directory updated? Is it available online and are hard copies available upon request?	

	Question	Offeror Response
99.	Other than provider directories and access to providers via your website, what quality or practice pattern data about your contracted providers do you make available to plan participants?	
100.	Identify any geographic limitations associated with your network(s) (i.e., PPO, HMO, Medicare Advantage) for the counties of Hawaii, Honolulu, Kauai, Maui, Kalaupapa and the Mainland.	
	Provider Contracting	
101.	Do you agree to notify members at no additional cost if an HMO network physician terminates their contract during the plan year (Y/N)?	
102.	Do you have a contractual relationship with outpatient facilities?	
103.	Describe any other contractual relationships with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers.	
104.	Do you have any special arrangements with "Center of Excellence" facilities?	
	a. Describe the illnesses/conditions and services associated with your Center of Excellence programs.	
	b. Are services bundled with regard to reimbursement?	
	c. Is the facility at risk for cost incurred in excess of the negotiated charge?	
	d. Include the actual bundled charge for each condition and list the facilities by name and region.	
105.	Do you agree to notify the EUTF immediately if the network loses any accreditation, licenses, or liability insurance coverage or if there is a change in hospital network contracts (Y/N)?	
106.	In the past 12 months, has your organization closed any network service areas (Y/N)? If yes, list the centers.	
	Provider Reimbursement	
107.	Provide a general description on how you establish your organization's networks (i.e., PPO, HMO, Medicare Advantage) and the corresponding financial arrangements.	
108.	Share your projected trends for 2024 and 2025 for each network (i.e., PPO, HMO, Medicare Advantage) being proposed.	
109.	Indicate what percentage (%) of provider reimbursement is through the following types of payments for each network (i.e., PPO,	Primary Care Physicians Specialist Physicians (%) Other Professionals (%)

	Question	Offeror Response	
	HMO, Medicare Advantage) being proposed. Each column should total 100%.	(%)	
	a. Fee-for-Service/Billed Charges	/	/
	b. Discount from Charges	/	/
	c. Fee-for-service with Discount	/	/
	d. Fee-for-service with Withhold	/	/
	e. Resource-based relative value scale	/	/
	f. Capitation	/	/
	g. Shared Savings Arrangement	/	/
	h. Other (specify)	/	/
110.	For your HMO network, detail the current referral process and identify any future changes your organization is considering, if any, to encourage physician organization risk-sharing.		
111.	Describe how network hospitals are reimbursed. Your answer should be consistent with the fees provided on the proposal sheets provided. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor.		
112.	How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, or pre-paid capitated arrangement)? If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.		
113.	Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement.		
114.	Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).		
	Provider Profiling		
115.	Do you have a mechanism for routinely investigating if a contracted provider has any disciplinary actions imposed by their State licensure medical board (Y/N)?		
116.	Do you compare individual network provider practice patterns against Best practices or averages on any of the following: (List all that apply.) a. Referral rates to specialists b. Frequency and quality of prescription drug dispensing c. Rates of diagnostic procedures ordered (lab/imaging)		

	Question	Offeror Response
	d. Rates of surgical procedure relative to peers e. Repeat procedures within given time frames f. Hospital readmission rates g. Unknown/Do not track	

117.	**Provider Terminations**					
	Oahu	**Maui**	**Hawaii**	**Kauai**	**Lanai**	**Molokai**
Hospitals						
# of terminations in the past 12 months						
% of contracted hospitals terminated						
% of terminations that were voluntary						
Main reason for terminations (e.g., contract dispute)						
Physicians						
# of terminations in the past 12 months						
% of contracted physicians terminated						
% of terminations that were voluntary						
Main reason for terminations (e.g., contract dispute, death, moved)						

	Question	Offeror Response
I	**INTEGRATED BENEFITS**	
	Prescription Drug Benefit	
118.	Do you use a subcontractor/vendor as your PBM (Y/N)? If yes, indicate and include if they manage both the non-specialty and specialty spend.	
119.	For a fully insured drug plan being proposed in place of our self-insured drug plan, do you agree to grandfather the formulary for 90 days (Y/N)?	
120.	What is your overall strategy for managing drug cost/utilization?	
121.	Do you audit your PBM's performance (Y/N)? If yes, explain and include frequency.	
	Chiropractic Benefit	
122.	Do you use a subcontractor/vendor to provide chiropractic benefits (Y/N)? If yes, indicate.	
123.	Do you audit claims processed by your subcontractor (Y/N)? If yes, explain and include frequency.	
J	**REPORTS**	
124.	Describe your ability to implement and methodology to report outcomes for core	

	Question	Offeror Response
	clinical programs and non-core (buy-up) programs.	
125.	What benchmarks will be used when comparing our utilization and cost data?	
K	**SURPRISE BILLING AND TRANSPARENCY RULE**	
126.	Can you confirm that you will be in compliance with the Federal law and Regulations concerning the Surprise Billing and Transparency Rule with respect to the services provided by your company?	
127.	Do you have any technical specifications for the EUTF in order to use any solution you intend to offer to comply with the law and regulations, including software, hardware, or other information technology?	
128.	Are the premium rates you propose inclusive of all services related to the law and regulations?	
129.	Is the cost associated with the services related to the law and regulations included in your proposed fees?	
130.	Do you have an internet-based self-service tool that makes available to the EUTF's enrollees real time cost-sharing information in accordance with the Transparency Rules?	
131.	Does your internet-based self-service tool comply with the Transparency Rules?	
132.	Will you make the tool available to the EUTF's enrollees through your website by providing information for the benefit plans?	
133.	How will the required enrollee notice of disclosure be provided?	
134.	How will you respond to enrollees who request the information in writing rather than through the web services?	
135.	Confirm you will provide the EUTF with any of the three machine readable files on a monthly basis including in-network rates, out-of-network allowed amounts, and prescription drug negotiated rates. If not, describe which file will be available.	
136.	Describe the information technology requirements necessary for transmitting files and/or posting them.	
137.	If the EUTF uses multiple service providers for in-network or out-of-network pricing, will you provide assistance in consolidating the information into one file?	
138.	Will you send information to the EUTF or provide another service to the EUTF that allows the EUTF to link you and another website?	

	Question	Offeror Response
139.	Do any contracts you are a party to contain language prohibiting disclosure of pricing terms ('gag clause") which will be prohibited under the No Surprises Act?	
140.	Confirm you have removed the gag clauses from contracts in force.	
141.	If the gag clauses have not been removed, on what date will all clauses be completely removed from your contracts?	
142.	Describe your process for paying for Emergency Services, Non-emergency Services provided at an In-Network Facility and Air Ambulance Services under the No Surprises Act.	
143.	Are there any subcontractors used in determining the amount to pay for Covered Services? Describe their services.	
144.	Describe your process for setting the Qualifying Payment Amount, Recognized Amount, and Out-of-Network Rates for Covered Services and assuring participant's cost-sharing is based on them.	
145.	If you are providing any preferred Network providers:	
	a) Describe how PPO contracts will be revised and what communications you will make to those providers concerning the No Surprise Act.	
	b) Describe any provider or facility billing processes and how they will be affected by the No Surprises Act.	
146.	Are there any State laws that affect your determination of the Recognized Amount for this plan? If so, please describe.	
147.	How will you determine whether a patient consented to services from an out-of-network provider in an In-Network facility (i.e., Anesthesiologist) and is therefore not reimbursed under the No Surprises Act?	
148.	What support will you provide to the EUTF if a healthcare provider or facility elects to negotiate an out-of-network payment amount or elects to conduct Independent Dispute Resolution (IDR)?	
149.	Will you prepare the IDR submission on behalf of the EUTF at no additional cost?	
150.	Will you pay IDR fees on behalf of the EUTF, including general assessments and fees if the EUTF is unsuccessful?	

	Question	Offeror Response
151.	Will the IDR submission be approved by the EUTF or will the process be delegated to you?	
152.	How will you assist the EUTF to pay for IDR, including the general assessment and specific charges for individual IDRS?	
153.	Will you assist the EUTF in providing a compliant process for plan participants who have a complaint about bills under the No Surprises Act?	
154.	Explain how the No Surprises Act will affect payment of Air Ambulance services under their plan and whether you will propose plan changes to this benefit.	
155.	The No Surprise Act required ID cards to contain information about deductibles and out-of-pocket maximums. Confirm that you will provide ID cards and they will be in compliance with the new regulations.	
156.	Explain how you will support the additional External Appeals requirements for Covered Services. Do you have a contract with an Independent Review Organization for external review?	
157.	Explain how you will provide plan participants with an Advanced Explanation of Benefits as required under ERISA Section 716(f); PHSA Section 2799A-1(f).	
158.	What process will be used to accept provider notification of expected charges and services?	
159.	Explain how you will provide the Advanced EOB to participants, i.e., via electronic means or mail as requested by participant.	
160.	Explain how you will provide reports assuring the Advanced EOB process is performing as required by law.	
161.	Will you provide a price comparison tool via internet websites and via telephone that allow a participant to compare the amount of cost sharing that they will be responsible for by participating provider and geographic region.	
162.	Describe the comparison tool in detail and whether any subcontractors are used to produce it.	
163.	Describe who will provide the telephone tool and at what location (for the price comparison tool).	
164.	Is there a dedicated team for the EUTF's participants to provide the price comparison tool and assist with its use.	

	Question	Offeror Response
165.	What internet website will be used for the price comparison tool and will the Plan need to provide its own website to link to the tool or will your company provide that site?	
166.	Explain the process for addressing participant or provider complaints that may be made against the plan under the No Surprise Act.	
167.	Do you provide the plan's external review services? If so, how will you incorporate emergency services and air ambulance services into the external review process?	
168.	Explain whether you will accept responsibility for fulfilling all cost reporting obligations and if not which ones will you not fulfill?	

ATTACHMENT 9

PLAN SUMMARIES AND FEE PROPOSAL

Complete the attached Attachment 9 in Excel format.

PROPOSAL SHEET 1A – PLAN SUMMARY
EUTF ACTIVE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	None	$100 per person		
		$300 per family		
Calendar Year Maximum Out-of-Pocket	$2,000 per person			
	$4,000 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	10%	30%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%	30%		
	(120 days/CY)			
Mental Health Services	10%	30%		
Emergency Services				
Emergency Room	10%	10%*		
Ambulance (air)	10%	10%*		
Ambulance (ground)	10%	30%		
Online Care				
Online Care	No charge	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	10%	30%		
Urgent Care	10%	30%		
Immunizations	No charge	No charge*		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	10%	30%		
Ambulatory Surgical Center (ASC)	10%	30%		
Anesthesia	10%	30%		
Outpatient Services				
Allergy Testing	10%	30%		
Diagnostic Testing	10%	30%		
Laboratory and Pathology	10%	30%		
Radiology	10%	30%		
Chemotherapy	10%	30%		
Radiation Therapy	10%	30%		
Physical and Occupational Therapy	10%	30%		
Mental Health Services	10%	30%		
Disease Management and Preventive Services				
Annual Preventive Health Evaluation	No charge	No charge*		
	(age 22 and over)	(age 22 and over)		
Diabetes Prevention Program	No charge	Not covered		
	(one program per lifetime)			
Disease Management Programs	No charge	Not covered		
Mammography Screening	No charge	30%		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	No charge	30%		
Reversing Heart Disease Program	10%	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge	30%*		
	(through age 21)	(through age 21)		
Other Services				
Advance Care Planning	No charge	30%		
Diabetic Supplies	10%	30%		
Durable Medical Equipment	10%	30%		
Hearing Aids	10%	30%		
	(one hearing aid per ear every 60 months)			
Home Health Care	No charge	30%		
	(150 visits/CY)			
Hospice Services	No charge	Not covered		
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	10%	30%		
Supportive Care	No charge	Not covered		
	(90 days/12-month period)			
Chiropractic Services***	$15	Not covered		
	(20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				

PROPOSAL SHEET 1A – PLAN SUMMARY
EUTF ACTIVE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 90/10 PPO PLAN			PROPOSED BENEFIT DEVIATION		
PRESCRIPTION DRUG (provided by CVS Caremark)†						
	In-Network Pharmacy	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**	**In-Network Pharmacy**	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	$4,350 per person					
	$8,700 per family					
Day Supply	30/60/90	30/60/90	30/60/90			
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20%	$50/$100/$100			
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Other Insulin	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Preferred Diabetic Supplies	No charge	20%	No charge			
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Oral Contraceptives (up to a 12-month supply)	No charge	20%	No charge			
Specialty Drugs/Injectables††	30-day supply only					
	$2,500/person CY MOOP					
	Specialty generic: 10% up to $200/fill					
	Specialty preferred brand: 20% up to $300/fill					
	Specialty non-preferred brand: 30% up to $400/fill					
	Oral oncology: $30					
	Mail: Not covered					

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
*** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under a separate contract.
†† Applicable copayments and caps for specialty medications apply and are counted toward the total annual MOOP.
††† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 1B – INSURED WITH RISK SHARING
EUTF ACTIVE 90/10 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Active 90/10 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 1C – SELF-INSURED ASO
EUTF ACTIVE 90/10 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Active 90/10 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 2A – PLAN SUMMARY
EUTF ACTIVE 80/20 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 80/20 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	None	$250 per person		
		$750 per family		
Calendar Year Maximum Out-of-Pocket	$2,500 per person			
	$5,000 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	20%	40%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	20%	40%		
	(120 days/CY)			
Mental Health Services	20%	40%		
Emergency Services				
Emergency Room	20%	20%*		
Ambulance (air)	20%	20%*		
Ambulance (ground)	20%	40%		
Online Care				
Online Care	No charge	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	20%	40%		
Urgent Care	20%	40%		
Immunizations	No charge	No charge*		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	20%	40%		
Ambulatory Surgical Center (ASC)	20%	40%		
Anesthesia	20%	40%		
Outpatient Services				
Allergy Testing	20%	40%		
Diagnostic Testing	20%	40%		
Laboratory and Pathology	20%	40%		
Radiology	20%	40%		
Chemotherapy	20%	40%		
Radiation Therapy	20%	40%		
Physical and Occupational Therapy	20%	40%		
Mental Health Services	20%	40%		
Disease Management and Preventive Services				
Annual Preventive Health Evaluation	No charge	No charge*		
	(age 22 and over)	(age 22 and over)		
Diabetes Prevention Program	No charge	Not covered		
	(one program per lifetime)			
Disease Management Programs	No charge	Not covered		
Mammography Screening	No charge	40%		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	No charge	40%		
Reversing Heart Disease Program	20%	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge	40%*		
	(through age 21)	(through age 21)		
Other Services				
Advance Care Planning	No charge	40%		
Diabetic Supplies	20%	40%		
Durable Medical Equipment	20%	40%		
Hearing Aids	20%	40%		
	(one hearing aid per ear every 60 months)			
Home Health Care	20%	40%		
	(150 visits/CY)			
Hospice Services	No charge	Not covered		
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	20%	40%		
Supportive Care	No charge	Not covered		
	(90 days/12-month period)			
Chiropractic Services***	$15	Not covered		
	(20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				

PROPOSAL SHEET 2A – PLAN SUMMARY
EUTF ACTIVE 80/20 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 80/20 PPO PLAN			PROPOSED BENEFIT DEVIATION		
PRESCRIPTION DRUG (provided by CVS Caremark)†						
	In-Network Pharmacy	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**	**In-Network Pharmacy**	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	$4,350 per person					
	$8,700 per family					
Day Supply	30/60/90	30/60/90	30/60/90			
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20%	$50/$100/$100			
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Other Insulin	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Preferred Diabetic Supplies	No charge	20%	No charge			
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Oral Contraceptives (up to a 12-month supply)	No charge	20%	No charge			
Specialty Drugs/Injectables††	30-day supply only					
	$2,500/person CY MOOP					
	Specialty generic: 10% up to $200/fill					
	Specialty preferred brand: 20% up to $300/fill					
	Specialty non-preferred brand: 30% up to $400/fill					
	Oral oncology: $30					
	Mail: Not covered					

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
*** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under a separate contract.
†† Applicable copayments and caps for specialty medications apply and are counted toward the total annual MOOP.
††† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 2B – INSURED WITH RISK SHARING
EUTF ACTIVE 80/20 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Active 80/20 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 2C – SELF-INSURED ASO
EUTF ACTIVE 80/20 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Active 80/20 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 3A – PLAN SUMMARY
EUTF ACTIVE 75/25 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 75/25 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	$300 per person			
	$900 per family			
Calendar Year Maximum Out-of-Pocket	$5,000 per person			
	$10,000 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	25%	40%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	25%	40%		
	(120 days/CY)			
Mental Health Services	Facility: 25%	40%		
	Physician visit: 25%*			
	Psych testing: 25%			
Emergency Services				
Emergency Room	25%	25%		
Ambulance (air)	25%	25%		
Ambulance (ground)	25%	40%		
Online Care				
Online Care	No charge*	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	25%*	40%		
Urgent Care	25%*	40%		
Immunizations	No charge*	No charge*		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	25%	40%		
Ambulatory Surgical Center (ASC)	25%	40%		
Anesthesia	25%	40%		
Outpatient Services				
Allergy Testing	25%	40%		
Diagnostic Testing	25%	40%		
Laboratory and Pathology	25%*	40%		
Radiology	25%	40%		
Chemotherapy	25%	40%		
Radiation Therapy	25%	40%		
Physical and Occupational Therapy	25%	40%		
Mental Health Services	Facility: 25%	40%		
	Physician visit: 25%*			
	Psych testing: 25%			
Disease Management and Preventive Services				
Annual Preventive Health Evaluation	No charge*	No charge*		
	(age 22 and over)	(age 22 and over)		
Diabetes Prevention Program	No charge*	Not covered		
	(one program per lifetime)			
Disease Management Programs	No charge*	Not covered		
Mammography Screening	No charge*	40%		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	No charge*	40%		
Reversing Heart Disease Program	25%*	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge*	40%*		
	(through age 21)	(through age 21)		
Other Services				
Advance Care Planning	No charge*	40%		
Diabetic Supplies	25%	40%		
Durable Medical Equipment	25%	40%		
Hearing Aids	25%	40%		
	(one hearing aid per ear every 60 months)			
Home Health Care	25%	40%		
	(150 visits/CY)			
Hospice Services	No charge	Not covered		
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	25%	40%		
Supportive Care	No charge	Not covered		
	(90 days/12-month period)			
Chiropractic Services***	$15*	Not covered		
	(20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				

PROPOSAL SHEET 3A – PLAN SUMMARY
EUTF ACTIVE 75/25 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE 75/25 PPO PLAN			PROPOSED BENEFIT DEVIATION		
PRESCRIPTION DRUG (provided by CVS Caremark)†						
	In-Network Pharmacy	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**	**In-Network Pharmacy**	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	$3,150 per person					
	$6,300 per family					
Day Supply	30/60/90	30/60/90	30/60/90			
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20%	$50/$100/$100			
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Other Insulin	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Preferred Diabetic Supplies	No charge	20%	No charge			
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Oral Contraceptives (up to a 12-month supply)	No charge	20%	No charge			
Specialty Drugs/Injectables††	30-day supply only					
	$2,500/person CY MOOP					
	Specialty generic: 10% up to $200/fill					
	Specialty preferred brand: 20% up to $300/fill					
	Specialty non-preferred brand: 30% up to $400/fill					
	Oral oncology: $30					
	Mail: Not covered					

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
*** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under a separate contract.
†† Applicable copayments and caps for specialty medications apply and are counted toward the total annual MOOP.
††† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 3B – INSURED WITH RISK SHARING
EUTF ACTIVE 75/25 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Active 75/25 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 3C – SELF-INSURED ASO
EUTF ACTIVE 75/25 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Active 75/25 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 4A – PLAN SUMMARY
EUTF PART-TIME AND TEMPORARY EMPLOYEE PPO PLAN

Provide a summary of the proposed plan design and member cost share. The proposed plan design must include essential health coverage as defined by ACA.

Plan Design	EUTF PART-TIME AND TEMPORARY EMPLOYEE PROPOSED BENEFIT	
MEDICAL		
	In-Network	**Out-of-Network**
Calendar Year Deductible	per person	
	per family	
Calendar Year Maximum Out-of-Pocket	per person	
	per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)		
Mental Health Services		
Emergency Services		
Emergency Room		
Ambulance (air)		
Ambulance (ground)		
Online Care		
Online Care		
Physician Services		
Physician Visits (including primary care and specialist office visits)		
Urgent Care		
Immunizations		
Surgical Services		
Surgical Procedures (including cutting and non-cutting surgery)		
Ambulatory Surgical Center (ASC)		
Anesthesia		
Outpatient Services		
Allergy Testing		
Diagnostic Testing		
Laboratory and Pathology		
Radiology		
Chemotherapy		
Radiation Therapy		
Physical and Occupational Therapy		
Mental Health Services		
Disease Management and Preventive Services		
Annual Preventive Health Evaluation		
Diabetes Prevention Program		
Disease Management Programs		
Mammography Screening		
Preventive Screening Services		
Reversing Heart Disease Program		
Well-Child Care Physician Office Visits		
Other Services		
Advance Care Planning		
Diabetic Supplies		
Durable Medical Equipment		
Hearing Aids		

PROPOSAL SHEET 4A – PLAN SUMMARY
EUTF PART-TIME AND TEMPORARY EMPLOYEE PPO PLAN

Provide a summary of the proposed plan design and member cost share. The proposed plan design must include essential health coverage as defined by ACA.

Plan Design	EUTF PART-TIME AND TEMPORARY EMPLOYEE		
	PROPOSED BENEFIT		
Home Health Care			
Hospice Services			
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit			
Supportive Care			
PRESCRIPTION DRUG			
	In-Network Pharmacy	**Out-of-Network Pharmacy**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP		
Day Supply	30/60/90	30/60/90	30/60/90
Generic			
Preferred Brand			
Non-Preferred Brand			
Preferred Insulin			
Other Insulin			
Preferred Diabetic Supplies			
Other Diabetic Supplies			
Oral Contraceptives (up to a 12-month supply)			
Specialty Drugs/Injectables			

PROPOSAL SHEET 4B – FULLY INSURED
EUTF PART-TIME AND TEMPORARY EMPLOYEE PPO PLAN

Complete the following table on a monthly per capita tiered basis only.

EUTF Part-Time and Temporary Employee PPO Plan	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
	7/1/25-6/30/26	7/1/26-6/30/27	7/1/27-6/30/28	7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical Benefit Cost (excluding Chiropractic):				
Self				
Two-Party				
Family				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, Chiropractic, and Prescription Drug):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical and Prescription Drug Premium):				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 5A – PLAN SUMMARY
EUTF ACTIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by HMSA)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$1,500 per person	
	$3,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	No charge	
	(120 days/CY)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$100	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$15 (OON in Hawaii or from a BlueCard provider outside Hawaii)	
Immunizations	No charge	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	No charge (outpatient surgical center)	
	$15 (outpatient professional charges)	
Ambulatory Surgical Center (ASC)	No charge	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	No charge	
Laboratory and Pathology	No charge	
Radiology	$15 per x-ray	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	Facility: No charge	
	Physician visits: $15	
	Psych testing: No charge	
Disease Management and Preventive Services		
Annual Preventive Health Evaluation	No charge	
	(age 22 and over)	
Diabetes Prevention Program	No charge	
	(one program per lifetime)	
Disease Management Programs	No charge	
Mammography Screening	No charge	
	(one baseline for women age 35-39, one per CY thereafter)	
Preventive Screening Services	No charge	
Reversing Heart Disease Program	$15 per session	
	(one program per lifetime)	
Well-Child Care Physician Office Visits	No charge	
	(through age 21)	
Other Services		
Advance Care Planning	No charge	
Diabetic Supplies	20%	
Durable Medical Equipment	20%	
Hearing Aids	20%	
	(one hearing aid per ear every 60 months)	
Home Health Care	No charge	
	(365 visits/illness or injury)	
Hospice Services	No charge	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge	
Supportive Care	No charge	
	(90 days/12-month period)	
Chiropractic Services**	$15	
	(20 visits/CY)	
Other benefit (not listed above where there is a proposed deviation):		

PROPOSAL SHEET 5A – PLAN SUMMARY
EUTF ACTIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE HMO PLAN			PROPOSED BENEFIT DEVIATION		
PRESCRIPTION DRUG (provided by CVS Caremark)†						
	In-Network Pharmacy	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**	**In-Network Pharmacy**	**Out-of-Network Pharmacy†††**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	$4,350 per person					
	$8,700 per family					
Day Supply	30/60/90	30/60/90	30/60/90			
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20%	$50/$100/$100			
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Other Insulin	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Preferred Diabetic Supplies	No charge	20%	No charge			
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20%	$25/$50/$50			
Oral Contraceptives (up to a 12-month supply)	No charge	20%	No charge			
Specialty Drugs/Injectables††	30-day supply only					
	$2,500/person CY MOOP					
	Specialty generic: 10% up to $200/fill					
	Specialty preferred brand: 20% up to $300/fill					
	Specialty non-preferred brand: 30% up to $400/fill					
	Oral oncology: $30					
	Mail: Not covered					

* Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under a separate contract.
†† Applicable copayments and caps for specialty medications apply and are counted toward the total annual MOOP.
††† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 5B – INSURED WITH RISK SHARING
EUTF ACTIVE HMO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Active HMO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 5C – SELF-INSURED ASO
EUTF ACTIVE HMO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Active HMO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
HMO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 6A – PLAN SUMMARY
EUTF ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$15 (in service area)	
	20% (out of service area)	
Immunizations	No charge	
	$15 (travel immunizations)	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	$15	
Laboratory and Pathology	$15	
Radiology	$15	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Physical Exam	No charge	
	(age 6 and over)	
Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Well-Child Care Physician Office Visits	No charge	
	(through age 5)	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	20%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge (including maternity and newborn inpatient stay)	

PROPOSAL SHEET 6A – PLAN SUMMARY
EUTF ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN		PROPOSED BENEFIT DEVIATION	
Chiropractic Services**	$15 (20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic*	Tier 1: $5/$10/$15	Tier 1: $5/$10/$10		
	Tier 2: $10/$20/$30	Tier 2: $10/$20/$20		
Brand	$35/$70/$105	$35/$70/$70		
Preferred Insulin	$35/$70/$105	$35/$70/$70		
Other Insulin	Generic: $10/$20/$30	Generic: $10/$20/$20		
Diabetic Supplies	Appropriate drug copays apply			
Oral Contraceptives (up to a 12-month supply)	No charge			
Specialty Drugs/Injectables	Retail: $75 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: No charge			

* Tier 1 drugs are Generic Maintenance Drugs, which are specific Generic Drugs to treat chronic conditions. Tier 2 drugs are Other Generic Drugs.
** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

PROPOSAL SHEET 6B – FULLY INSURED
EUTF ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

EUTF Active Closed Panel Comprehensive HMO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical Benefit Cost (excluding Chiropractic):				
Self				
Two-Party				
Family				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, Prescription Drug, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical and Prescription Drug Premium):				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 7A – PLAN SUMMARY
EUTF ACTIVE CLOSED PANEL STANDARD HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE CLOSED PANEL STANDARD HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,500 per person	
	$7,500 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	15%	
Skilled Nursing Facility	15%	
	(60 days/benefit period)	
Mental Health Services	15%	
Emergency Services		
Emergency Room	$100	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	15% (inpatient)	
	$20 (outpatient)	
Urgent Care	$20 (in service area)	
	20% (out of service area)	
Immunizations	No charge	
	$20 (travel immunizations)	
Surgical Services		
Surgical Procedures	15% (inpatient)	
	$20 (outpatient)	
Ambulatory Surgical Center (ASC)	15%	
Anesthesia	15% (inpatient)	
	$20 (outpatient)	
Outpatient Services		
Allergy Testing	$20	
Diagnostic Testing	20%	
Laboratory and Pathology	$20 (basic)	
	20% (specialty)	
Radiology	$20 (basic)	
	20% (specialty)	
Chemotherapy	$20	
Radiation Therapy	20%	
Physical and Occupational Therapy	$20	
Mental Health Services	$20	
Disease Management and Preventive Services		
Annual Physical Exam	No charge	
	(age 6 and over)	
Diabetes Prevention Program	No charge	
Disease Management Programs	$20	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Well-Child Care Physician Office Visits	No charge	
	(through age 5)	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	50%	
Durable Medical Equipment	15% (inpatient)	
	50% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	

PROPOSAL SHEET 7A – PLAN SUMMARY
EUTF ACTIVE CLOSED PANEL STANDARD HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE CLOSED PANEL STANDARD HMO PLAN		PROPOSED BENEFIT DEVIATION	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge (routine prenatal visits and one postpartum visit)			
	15% (delivery, maternity and newborn inpatient stay)			
Chiropractic Services**	$15			
	(20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic*	Tier 1: $5/$10/$15	Tier 1: $5/$10/$10		
	Tier 2: $15/$30/$45	Tier 2: $15/$30/$30		
Brand	$50/$100/$150	$50/$100/$100		
Preferred Insulin	$50/$100/$150	$50/$100/$100		
Other Insulin	Generic: $15/$30/$45	Generic: $15/$30/$30		
Diabetic Supplies	50%			
Oral Contraceptives (up to a 12-month supply)	No charge			
Specialty Drugs/Injectables	Retail: $75 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: $20			

* Tier 1 drugs are Generic Maintenance Drugs, which are specific Generic Drugs to treat chronic conditions. Tier 2 drugs are Other Generic Drugs.
** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

PROPOSAL SHEET 7B – FULLY INSURED
EUTF ACTIVE CLOSED PANEL STANDARD HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

EUTF Closed Panel Standard HMO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical Benefit Cost (excluding Chiropractic):				
Self				
Two-Party				
Family				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, Prescription Drug, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical and Prescription Drug Premium):				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 8A – PLAN SUMMARY
EUTF PART-TIME AND TEMPORARY EMPLOYEE CLOSED PANEL HMO PLAN

Provide a summary of the proposed plan design and member cost share. The proposed plan design must include essential health coverage as defined by ACA.

Plan Design	EUTF PART-TIME AND TEMPORARY EMPLOYEE PROPOSED BENEFIT
MEDICAL	
	HMO Network
Calendar Year Deductible	
Calendar Year Maximum Out-of-Pocket	per person
	per family
Lifetime Benefit Maximum	None
Inpatient Services	
Inpatient Hospital Services (including room and board and ancillary services)	
Skilled Nursing Facility	
Mental Health Services	
Emergency Services	
Emergency Room	
Ambulance (air)	
Ambulance (ground)	
Online Care	
Online Care	
Physician Services	
Physician Visits (including primary care and specialist office visits)	
Urgent Care	
Immunizations	
Surgical Services	
Surgical Procedures	
Ambulatory Surgical Center (ASC)	
Anesthesia	
Outpatient Services	
Allergy Testing	
Diagnostic Testing	
Laboratory and Pathology	
Radiology	
Chemotherapy	
Radiation Therapy	
Physical and Occupational Therapy	
Mental Health Services	
Disease Management and Preventive Services	
Annual Physical Exam	
Diabetes Prevention Program	
Disease Management Programs	
Mammography Screening	
Preventive Screening Services	
Well-Child Care Physician Office Visits	
Other Services	
Advance Care Planning	
Diabetes Equipment	
Durable Medical Equipment	
Hearing Aids	
Home Health Care	
Hospice Services	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	

PROPOSAL SHEET 8A – PLAN SUMMARY
EUTF PART-TIME AND TEMPORARY EMPLOYEE CLOSED PANEL HMO PLAN

Provide a summary of the proposed plan design and member cost share. The proposed plan design must include essential health coverage as defined by ACA.

Plan Design	EUTF PART-TIME AND TEMPORARY EMPLOYEE	
	PROPOSED BENEFIT	
PRESCRIPTION DRUG		
	HMO Network	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP	
Day Supply	30/60/90	
Generic		
Brand		
Preferred Insulin		
Other Insulin		
Diabetic Supplies		
Oral Contraceptives (up to a 12-month supply)		
Specialty Drugs/Injectables		

PROPOSAL SHEET 8B – FULLY INSURED
EUTF PART-TIME AND TEMPORARY EMPLOYEE CLOSED PANEL HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

EUTF Part-Time and Temporary Employee Closed Panel HMO Plan	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
	7/1/25-6/30/26	7/1/26-6/30/27	7/1/27-6/30/28	7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical and Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical and Prescription Drug Premium):				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 9A – PLAN SUMMARY
EUTF ACTIVE SUPPLEMENTAL PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF ACTIVE SUPPLEMENTAL PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL AND PRESCRIPTION DRUG (provided by HMA)		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	None	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	All Services: $2,750 per person, including the Prescription Drug Sublimit listed below	
Prescription Drug Sublimit	$250 per person	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	Copay/Coinsurance covered	
Skilled Nursing Facility	Copay/Coinsurance covered	
Mental Health Services	Copay/Coinsurance covered	
Emergency Services		
Emergency Room	Copay/Coinsurance covered	
Ambulance (air)	Copay/Coinsurance covered	
Ambulance (ground)	Copay/Coinsurance covered	
Physician Services		
Physician Visits (including primary care and specialist office visits)	Copay/Coinsurance covered	
Urgent Care	Copay/Coinsurance covered	
Immunizations	Copay/Coinsurance covered	
Surgical Services		
Surgical Procedures	Copay/Coinsurance covered	
Ambulatory Surgical Center (ASC)	Copay/Coinsurance covered	
Anesthesia	Copay/Coinsurance covered	
Outpatient Services		
Allergy Testing	Copay/Coinsurance covered	
Diagnostic Testing	Copay/Coinsurance covered	
Laboratory and Pathology	Copay/Coinsurance covered	
Radiology	Copay/Coinsurance covered	
Chemotherapy	Copay/Coinsurance covered	
Radiation Therapy	Copay/Coinsurance covered	
Physical and Occupational Therapy	Copay/Coinsurance covered	
Mental Health Services	Copay/Coinsurance covered	
Disease Management and Preventive Services		
Annual Physical Exam	Copay/Coinsurance covered	
Mammography Screening	Copay/Coinsurance covered	
Preventive Screening Services	Copay/Coinsurance covered	
Well-Child Care Physician Office Visits	Copay/Coinsurance covered	
Other Services		
Diabetic Supplies	Copay/Coinsurance covered	
Durable Medical Equipment	Copay/Coinsurance covered	
Hearing Aids	Not covered	
Home Health Care	Copay/Coinsurance covered	
Hospice Services	Copay/Coinsurance covered	
Maternity Care	Copay/Coinsurance covered	
Chiropractic Services	Not covered	
Prescription Drug Copay Reimbursement	Shall not exceed $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply. Counts toward the Plan Year Benefit Maximum.	
Other benefit (not listed above where there is a proposed deviation):		

PROPOSAL SHEET 9B – SELF-INSURED ASO
EUTF ACTIVE SUPPLEMENTAL PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Active Supplemental Plan	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
	7/1/25-6/30/26	7/1/26-6/30/27	7/1/27-6/30/28	7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly ASO Fees (PEPM):				
Claims Adjudication Fee				
Other (including costs for ID cards, SPDs, data reporting, toll-free line, banking, and implementation)				
Total ASO Fees (PEPM):				
Total ASO Fees by Tier:				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 10A – PLAN SUMMARY
HSTA VB ACTIVE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	None	$100 per person		
		$300 per family		
Calendar Year Maximum Out-of-Pocket	$2,000 per person			
	$4,000 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	10%	30%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%	30%		
	(120 days/CY)			
Mental Health Services	10%	30%		
Emergency Services				
Emergency Room	10%	10%*		
Ambulance (air)	10%	10%*		
Ambulance (ground)	10%	30%		
Online Care				
Online Care	No charge	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	10%	30%		
Urgent Care	10%	30%		
Immunizations	No charge	30%		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	10%	30%		
Ambulatory Surgical Center (ASC)	10%	30%		
Anesthesia	10%	30%		
Outpatient Services				
Allergy Testing	10%	30%		
Diagnostic Testing	10%	30%		
Laboratory and Pathology	10%	30%		
Radiology	10%	30%		
Chemotherapy	10%	30%		
Radiation Therapy	10%	30%		
Physical and Occupational Therapy	10%	30%		
Mental Health Services	10%	30%		
Disease Management and Preventive Services				
Annual Physical Exam	No charge	No charge*		
	(age 22 and over)	(age 22 and over)		
Diabetes Prevention Program	No charge	Not covered		
	(one program per lifetime)			
Disease Management Programs	No charge	Not covered		
Mammography Screening	No charge	30%		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	No charge	30%		
Reversing Heart Disease Program	10%	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge	30%*		
	(through age 21)	(through age 21)		
Other Services				
Advance Care Planning	No charge	30%		
Diabetic Supplies	10%	30%		
Durable Medical Equipment	10%	30%		
Hearing Aids	10%	30%		
	(one hearing aid per ear every 60 months)			

PROPOSAL SHEET 10A – PLAN SUMMARY
HSTA VB ACTIVE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
Home Health Care	No charge (150 visits/CY)	30%		
Hospice Services	No charge	Not covered		
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	10%	30%		
Supportive Care	No charge (90 days/12-month period)	Not covered		
Chiropractic Services***	$12 (20 visits/CY)	Not covered		
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by CVS Caremark)†				
	In-Network Pharmacy/ Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/ Mail Order**	**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	$4,350 per person $8,700 per family			
Day Supply	30/60/90	30/60/90		
Generic	$5/$9/$9	$5/$9/$9 + 30%		
Brand	$15/$27/$27	$15/$27/$27 + 30%		
Insulin	$5/$9/$9	$5/$9/$9 + 30%		
Diabetic Supplies	No charge	30%		
Oral Contraceptives (up to a 12-month supply)	No charge	30%		
Specialty Drugs/Injectables	30-day supply only Appropriate drug copays apply Oral oncology: No charge Mail: Not covered			

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
*** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under a separate contract.
†† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.

PROPOSAL SHEET 10B – INSURED WITH RISK SHARING
HSTA VB ACTIVE 90/10 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB Active 90/10 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 10C – SELF-INSURED ASO
HSTA VB ACTIVE 90/10 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

HSTA VB Active 90/10 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 11A – PLAN SUMMARY
HSTA VB ACTIVE 80/20 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE 80/20 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Calendar Year Deductible	None			
Calendar Year Maximum Out-of-Pocket	$2,500 per person			
	$5,000 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	20%	20%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	20%	20%		
	(120 days/CY)			
Mental Health Services	20%	20%		
Emergency Services				
Emergency Room	20%	20%		
Ambulance (air)	20%	20%		
Ambulance (ground)	20%	20%		
Online Care				
Online Care	No charge	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	20%	20%		
Urgent Care	20%	20%		
Immunizations	No charge	No charge		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	20%	20%		
Ambulatory Surgical Center (ASC)	20%	20%		
Anesthesia	20%	20%		
Outpatient Services				
Allergy Testing	20%	20%		
Diagnostic Testing	20%	20%		
Laboratory and Pathology	No charge	No charge		
Radiology	20%	20%		
Chemotherapy	20%	20%		
Radiation Therapy	20%	20%		
Physical and Occupational Therapy	20%	20%		
Mental Health Services	20%	20%		
Disease Management and Preventive Services				
Annual Physical Exam	No charge	No charge		
	(age 22 and over)	(age 22 and over)		
Diabetes Prevention Program	No charge	Not covered		
	(one program per lifetime)			
Disease Management Programs	No charge	Not covered		
Mammography Screening	No charge	No charge		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	No charge	No charge		
Reversing Heart Disease Program	20%	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge	No charge		
	(through age 21)	(through age 21)		
Other Services				
Advance Care Planning	No charge	20%		
Diabetic Supplies	20%	20%		
Durable Medical Equipment	20%	20%		
Hearing Aids	20%	20%		
	(one hearing aid per ear every 60 months)			
Home Health Care	No charge	No charge		
	(150 visits/CY)			
Hospice Services	No charge	No charge		

PROPOSAL SHEET 11A – PLAN SUMMARY
HSTA VB ACTIVE 80/20 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE 80/20 PPO PLAN		PROPOSED BENEFIT DEVIATION	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	20%	20%		
Supportive Care	No charge (90 days/12-month period)	Not covered		
Chiropractic Services**	$12 (20 visits/CY)	Not covered		
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by CVS Caremark)†				
	In-Network Pharmacy/ Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/ Mail Order**	**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	$4,350 per person $8,700 per family			
Day Supply	30/60/90	30/60/90		
Generic	$5/$9/$9	$5/$9/$9 + 30%		
Brand	$15/$27/$27	$15/$27/$27 + 30%		
Insulin	$5/$9/$9	$5/$9/$9 + 30%		
Diabetic Supplies	No charge	30%		
Oral Contraceptives (up to a 12-month supply)	No charge	30%		
Specialty Drugs/Injectables	30-day supply only Appropriate drug copays apply Oral oncology: No charge Mail: Not covered			

* Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.

** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

† Prescription drug benefits are currently provided under a separate contract.

†† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.

PROPOSAL SHEET 11B – INSURED WITH RISK SHARING
HSTA VB ACTIVE 80/20 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB Active 80/20 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical Benefit Cost (excluding DM/IHM and Chiropractic):				
Self				
Two-Party				
Family				
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Self				
Two-Party				
Family				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Prescription Drug Premium (including Administration and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Self				
Two-Party				
Family				
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 11C – SELF-INSURED ASO
HSTA VB ACTIVE 80/20 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

HSTA VB Active 80/20 PPO Plan	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 12A – PLAN SUMMARY
HSTA VB ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$15 (in service area)	
	20% (out of service area)	
Immunizations	No charge	
	$15 (travel immunizations)	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	$15	
Laboratory and Pathology	$15	
Radiology	$15	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Physical Exam	No charge	
	(age 6 and over)	
Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Well-Child Care Physician Office Visits	No charge	
	(through age 5)	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	50%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge (including maternity and newborn inpatient stay)	

PROPOSAL SHEET 12A – PLAN SUMMARY
HSTA VB ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN		PROPOSED BENEFIT DEVIATION	
Chiropractic Services*	$12 (20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic	$10/$20/$30	$10/$20/$20		
Brand	$10/$20/$30	$10/$20/$20		
Insulin	$10/$20/$30	$10/$20/$20		
Diabetic Supplies	50%			
Oral Contraceptives (up to a 12-month supply)	No charge			
Specialty Drugs/Injectables	Retail: $10 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: No charge			

* The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

PROPOSAL SHEET 12B – FULLY INSURED
HSTA VB ACTIVE CLOSED PANEL COMPREHENSIVE HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

HSTA VB Active Closed Panel Comprehensive HMO Plan	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
	7/1/25-6/30/26	7/1/26-6/30/27	7/1/27-6/30/28	7/1/28-6/30/29
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical Benefit Cost (excluding Chiropractic):				
Self				
Two-Party				
Family				
Monthly Prescription Drug Benefit Cost:				
Self				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Self				
Two-Party				
Family				
Subtotal Benefit Cost (including Medical, Prescription Drug, and Chiropractic):				
Self				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Self				
Two-Party				
Family				
Monthly Retention:				
Self				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (including Benefit Cost, Administration, and Retention):				
Self				
Two-Party				
Family				
Monthly ACA PCORI Fee (to be added to the above Total Medical and Prescription Drug Premium):				
Self				
Two-Party				
Family				

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 13A – PLAN SUMMARY
EUTF RETIREE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF NON-MEDICARE RETIREE AND MEDICARE RETIREE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	$100 per person			
	$300 per family			
Calendar Year Maximum Out-of-Pocket	$2,500 per person			
	$7,500 per family			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	10%*	30%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%*	30%		
	(120 days/CY)			
Mental Health Services	10%*	30%		
Emergency Services				
Emergency Room	10%*	10%*		
Ambulance (air)	20%	20%		
Ambulance (ground)	20%	30%		
Online Care				
Online Care	No charge*	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	10%*	30%		
Urgent Care	10%*	30%		
Immunizations	No charge*	No charge		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	10%*	30%		
Ambulatory Surgical Center (ASC)	10%*	30%		
Anesthesia	10%*	30%		
Outpatient Services				
Allergy Testing	20%	30%		
Diagnostic Testing	20%*	30%		
Laboratory and Pathology	20%*	30%		
Radiology	20%*	30%		
Chemotherapy	20%	30%		
Radiation Therapy	20%*	30%		
Physical and Occupational Therapy	20%	30%		
Mental Health Services	Facility: 10%*	30%		
	Physician visit: 10%*			
	Psych testing: 20%*			
Disease Management and Preventive Services				
Annual Physical Exam	No charge*	30%*		
	(age 7 and over)	(age 7 and over)		
Diabetes Prevention Program	Not covered	Not covered		
Disease Management Programs	No charge*	Not covered		
Mammography Screening	20%*	30%*		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	20%*	30%		
Reversing Heart Disease Program	10%*	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge*	30%*		
	(through age 6)	(through age 6)		
Other Services				
Advance Care Planning	No charge*	10%*		
Diabetic Supplies	20%	30%		
Durable Medical Equipment	20%	30%		
Hearing Aids	20%	30%		
	(one hearing aid per ear every 60 months)			
Home Health Care	No charge*	30%		
	(150 visits/CY)			
Hospice Services	No charge*	Not covered		
Maternity Care - Routine Prenatal Visits, Delivery, and One Postpartum Visit	10%*	30%		
Supportive Care	No charge*	Not covered		
	(90 days/12-month period)			
Chiropractic Services***	Not covered	Not covered		
Other benefit (not listed above where there is a proposed deviation):				

EUTF NON-MEDICARE RETIREE PRESCRIPTION DRUG (provided by CVS Caremark)†						
	In-Network Pharmacy	**Out-of-Network Pharmacy††**	**Retail 90/Mail Order**	**In-Network Pharmacy**	**Out-of-Network Pharmacy††**	**Retail 90/Mail Order**
Calendar Year Maximum Out-of-Pocket	None					
Day Supply	30/60/90	30/60/90	30/60/90			
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Preferred Brand	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30			
Non-Preferred Brand	$30/$60/$90	$30/$60/$90 + 20%	$30/$60/$60			
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10			
Other Insulin	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30			
Preferred Diabetic Supplies	No charge	20%	No charge			
Other Diabetic Supplies	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30			
Specialty Drugs/Injectables	30-day supply only					
	$2,000/person CY MOOP					
	20% up to $250/fill					

PROPOSAL SHEET 13A – PLAN SUMMARY
EUTF RETIREE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF NON-MEDICARE RETIREE AND MEDICARE RETIREE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION		
	Oral oncology: $30				
	Mail: Not covered				
EUTF MEDICARE RETIREE					
EGWP PRESCRIPTION DRUG (provided by SilverScript)†					
	In-Network Pharmacy/Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/Mail Order**		**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	None				
Day Supply	30/60/90	30/60/90			
Generic	$5/$10/$10	$5/$10/$10 + 20%			
Preferred Brand	$15/$30/$30	$15/$30/$30 + 20%			
Non-Preferred Brand	$30/$60/$60	$30/$60/$60 + 20%			
Insulin	$5/$10/$10	$5/$10/$10 + 20%			
Diabetic Supplies	No charge	20%			
	Meters: Covered by Medicare Part B and the medical plan	Meters: Covered by Medicare Part B and the medical plan			
Specialty Drugs/Injectables	30-day supply only	50%			
	$2,000/person CY MOOP				
	20% up to $250/fill				
	Oral oncology: $30	Oral oncology: $30 + 20% (up to a 30-day supply)			
	Mail Order: Not covered				

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.
*** There currently is no chiropractic benefit under this plan. However, please include the proposed rate on a tiered basis if adopted at the start of the contract term, as a separate attachment.
† Prescription drug benefits are currently provided under a separate contract.
†† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 13B – INSURED WITH RISK SHARING
EUTF RETIREE 90/10 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Retiree 90/10 PPO Plan	Plan Year 1 1/1/25-12/31/25		Plan Year 2 1/1/26-12/31/26		Plan Year 3 1/1/27-12/31/27		Plan Year 4 1/1/28-12/31/28	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL								
Monthly Medical (Excluding DM/IHM) Benefit Cost:								
Self								
Two-Party								
Family								
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:								
Self								
Two-Party								
Family								
Subtotal Benefit Cost (including Medical and DM/IHM):								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):			_____%	_____%	_____%	_____%	_____%	_____%
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Medical Premium (including Benefit Cost, Administration, and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):								
Self								
Two-Party								
Family								
PRESCRIPTION DRUG								
Monthly Prescription Drug Benefit Cost:								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):			_____%		_____%		_____%	
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Prescription Drug Premium (including Administration and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):								
Self								
Two-Party								
Family								
Disease Management / Integrated Health Management (DM/IHM)								
DM/IHM benefit cost on a PEPM basis:								
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):								
Detailed breakout of the DM/IHM services and costs on a PEPM basis:								

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 13C – SELF-INSURED ASO
EUTF RETIREE 90/10 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

EUTF Retiree 90/10 PPO Plan	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DMIHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 14A – PLAN SUMMARY
EUTF RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF NON-MEDICARE RETIREE CLOSED PANEL HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50 (in service area)	
	20% (out of service area)	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$15 (in service area)	
	20% (out of service area)	
Immunizations	No charge	
	$15 (travel immunizations)	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	$15	
Laboratory and Pathology	$15	
Radiology	$15	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Physical Exam	No charge	
	(age 6 and over)	
Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Well-Child Care Physician Office Visits	No charge	
	(through age 5)	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	20%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge (including maternity and newborn inpatient stay)	

PROPOSAL SHEET 14A – PLAN SUMMARY
EUTF RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF NON-MEDICARE RETIREE CLOSED PANEL HMO PLAN		PROPOSED BENEFIT DEVIATION	
Chiropractic Services*	Not covered			
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic	$15/$30/$45	$15/$30/$30		
Brand	$15/$30/$45	$15/$30/$30		
Insulin	$15/$30/$45	$15/$30/$30		
Diabetic Supplies	$15/$30/$45	$15/$30/$30		
Oral Contraceptives (up to a 12-month supply)	50%			
Specialty Drugs/Injectables	Retail: $15 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: No charge			

* There currently is no chiropractic benefit under this plan. However, please include the proposed rate on a tiered basis if adopted at the start of the contract term, as a separate attachment.

PROPOSAL SHEET 14A – PLAN SUMMARY
EUTF RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF MEDICARE RETIREE CLOSED PANEL HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50 (worldwide)	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$20 (worldwide)	
Immunizations	No charge	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	No charge	
Laboratory and Pathology	No charge	
Radiology	No charge	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Wellness Visit	No charge	
Annual Physical Exam	No charge	
Medicare Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	20%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	
Maternity Care	No charge	
Silver&Fit Healthy Aging and Exercise Program	No charge	
Chiropractic Services*	$15 (Medicare-covered services only)	
Other benefit (not listed above):		

PROPOSAL SHEET 14A – PLAN SUMMARY
EUTF RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF MEDICARE RETIREE CLOSED PANEL HMO PLAN		PROPOSED BENEFIT DEVIATION	
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic	$15/$30/$45	$15/$30/$30		
Brand	$15/$30/$45	$15/$30/$30		
Insulin	$15/$30/$45	$15/$30/$30		
Diabetic Supplies	Lancets, Strips & Meters: 20%	Lancets, Strips & Meters: 20%		
	Syringes/Needles: $15/$30/$45	Syringes/Needles: $15/$30/$30		
Specialty Drugs/Injectables	Retail: $15 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: $15			

* There currently is no chiropractic benefit (other than Medicare-covered services) under this plan. However, please include the proposed rate on a tiered basis if adopted at the start of the contract term, as a separate attachment.

PROPOSAL SHEET 14B – FULLY INSURED
EUTF RETIREE CLOSED PANEL HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

EUTF Retiree Closed Panel HMO Plan	Plan Year 1 1/1/25-12/31/25		Plan Year 2 1/1/26-12/31/26		Plan Year 3 1/1/27-12/31/27		Plan Year 4 1/1/28-12/31/28	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL AND PRESCRIPTION DRUG								
Monthly Medical Benefit Cost:								
Self								
Two-Party								
Family								
Monthly Silver&Fit Healthy Aging and Exercise Program Cost:								
Self	NA		NA		NA		NA	
Two-Party	NA		NA		NA		NA	
Family	NA		NA		NA		NA	
Monthly Prescription Drug Benefit Cost:								
Self								
Two-Party								
Family								
Subtotal Benefit Cost (including Medical, Silver&Fit, and Prescription Drug):								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):			_____%	_____%	_____%	_____%	_____%	_____%
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Medical and Prescription Drug Premium (including Benefit Cost, Administration, and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):								
Self								
Two-Party								
Family								

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 15A – PLAN SUMMARY
EUTF RETIREE MEDICARE ADVANTAGE LPPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF MEDICARE RETIREE MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by Humana)				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$100 per person			
Calendar Year Maximum Out-of-Pocket	$2,500 per person			
Lifetime Benefit Maximum	None			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	10%	10%		
Skilled Nursing Facility	Days 1-20: No charge	Days 1-20: No charge		
	Days 21-120: 10%	Days 21-120: 10%		
	(120 days/benefit period)			
Mental Health Services	10%	10%		
	(190-day lifetime limit in a psychiatric facility)			
Emergency Services				
Emergency Room	10%*	10%*		
	(waived if admitted within 24 hours)			
Ambulance (air)	10%	10%		
Ambulance (ground)	10%	10%		
Physician Services				
Physician Visits (including primary care and specialist office visits)	10%*	10%*		
Urgent Care	10%*	10%*		
Immunizations	No charge*	No charge*		
Surgical Services				
Surgical Procedures	10%	10%		
Ambulatory Surgical Center (ASC)	10%	10%		
Anesthesia	10%	10%		
Outpatient Services				
Allergy Testing	10%	10%		
Diagnostic Testing	10%	10%		
Laboratory and Pathology	10%	10%		
Radiology	10%	10%		
Chemotherapy	10%	10%		
Radiation Therapy	10%	10%		
Physical and Occupational Therapy	10%	10%		
Mental Health Services	Facility: 10%	Facility: 10%		
	Physician visit: 10%*	Physician visit: 10%*		
	Psych testing: 10%	Psych testing: 10%		
Disease Management and Preventive Services				
Annual Wellness Visit	No charge*	No charge*		
Annual Physical Exam	No charge*	No charge*		
Medicare Diabetes Prevention Program	No charge*	No charge*		
	(one program per lifetime)			
Disease Management Programs	No charge*	Not covered		
Mammography Screening	No charge*	No charge*		
Preventive Screening Services	No charge*	No charge*		
Other Services				
Advance Care Planning	No charge*	Not covered		
Diabetic Supplies	10%	10%		
Durable Medical Equipment	10%	10%		
Hearing Aids	20%	20%		
	(one hearing aid per ear every 60 months)			
Home Health Care	No charge*	No charge*		
Hospice Services	Covered by Original Medicare			
Chiropractic Services**	10%*	10%*		
	(Medicare-covered services only)			
Other benefit (not listed above where there is a proposed deviation):				

PROPOSAL SHEET 15A – PLAN SUMMARY
EUTF RETIREE MEDICARE ADVANTAGE LPPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	EUTF MEDICARE RETIREE MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)		PROPOSED BENEFIT DEVIATION	
EGWP PRESCRIPTION DRUG (provided by SilverScript)†				
	In-Network Pharmacy/Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/Mail Order**	**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	None			
Day Supply	30/60/90	30/60/90		
Generic	$5/$10/$10	$5/$10/$10 + 20%		
Preferred Brand	$15/$30/$30	$15/$30/$30 + 20%		
Non-Preferred Brand	$30/$60/$60	$30/$60/$60 + 20%		
Insulin	$5/$10/$10	$5/$10/$10 + 20%		
Diabetic Supplies	No charge	20%		
	Meters: Covered by Medicare Part B and the medical plan	Meters: Covered by Medicare Part B and the medical plan		
Specialty Drugs/Injectables	30-day supply only	50%		
	$2,000/person CY MOOP			
	20% up to $250/fill			
	Oral oncology: $30	Oral oncology: $30 + 20% (up to a 30-day supply)		
	Mail Order: Not covered			

* Deductible does not apply.
** There currently is no chiropractic benefit (other than Medicare-covered services) under this plan. However, please include the proposed rate on a tiered basis if adopted at the start of the contract term, as a separate attachment.
† Prescription drug benefits are currently provided under a separate contract.
†† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.
Note: Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.

PROPOSAL SHEET 15B – FULLY INSURED
EUTF RETIREE MEDICARE ADVANTAGE LPPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Retiree Medicare Advantage LPPO Plan	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
MEDICAL				
Monthly Medical Benefit Cost:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly Retention:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Total Medical Premium (including Administration and Retention):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
PRESCRIPTION DRUG				
Monthly Prescription Drug Benefit Cost:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):		_____%	_____%	_____%
Monthly Administration:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly Retention:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Total Prescription Drug Premium (including Administration and Retention):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 16A – PLAN SUMMARY
HSTA VB RETIREE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB NON-MEDICARE RETIREE AND MEDICARE RETIREE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
MEDICAL (provided by HMSA)				
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****
Calendar Year Deductible	None	$100 per person		
		$300 per family		
Calendar Year Maximum Out-of-Pocket	$2,000 per person			
	$6,000 per family			
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/CY thereafter			
Inpatient Services				
Inpatient Hospital Services (including room and board and ancillary services)	10%	30%		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%	30%		
	(120 days/CY)			
Mental Health Services	10%	30%		
Emergency Services				
Emergency Room	10%	10%*		
Ambulance (air)	10%	10%*		
Ambulance (ground)	10%	30%		
Online Care				
Online Care	No charge (not subject to lifetime max)	Not covered		
Physician Services				
Physician Visits (including primary care and specialist office visits)	10%	30%		
Urgent Care	10%	30%		
Immunizations	No charge	30%		
Surgical Services				
Surgical Procedures (including cutting and non-cutting surgery)	10%	30%		
Ambulatory Surgical Center (ASC)	10%	30%		
Anesthesia	10%	30%		
Outpatient Services				
Allergy Testing	10%	30%		
Diagnostic Testing	10%	30%		
Laboratory and Pathology	10%	30%		
Radiology	10%	30%		
Chemotherapy	10%	30%		
Radiation Therapy	10%	30%		
Physical and Occupational Therapy	10%	30%		
Mental Health Services	10%	30%		
Disease Management and Preventive Services				
Annual Physical Exam	Benefit max varies depending on age	Benefit max varies depending on age*		
	(age 7 and over)	(age 7 and over)		
Diabetes Prevention Program	Not covered	Not covered		
Disease Management Programs	No charge	Not covered		
Mammography Screening	10%	30%		
	(one baseline for women age 35-39, one per CY thereafter)			
Preventive Screening Services	10%	30%		
Reversing Heart Disease Program	10%	Not covered		
	(one program per lifetime)			
Well-Child Care Physician Office Visits	No charge	30%*		
	(through age 6)	(through age 6)		
Other Services				
Advance Care Planning	No charge	30%		
Diabetic Supplies	10%	30%		
Durable Medical Equipment	10%	30%		

PROPOSAL SHEET 16A – PLAN SUMMARY
HSTA VB RETIREE 90/10 PPO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB NON-MEDICARE RETIREE AND MEDICARE RETIREE 90/10 PPO PLAN		PROPOSED BENEFIT DEVIATION	
Hearing Aids	10%	30%		
	(one hearing aid per ear every 60 months)			
Home Health Care	No charge	30%		
	(150 visits/CY)			
Hospice Services	No charge	Not covered		
Maternity Care – Routine Prenatal Visits, Delivery, and One Postpartum Visit	10%	30%		
Supportive Care	No charge	Not covered		
	(90 days/12-month period)			
Chiropractic Services***	$12	Not covered		
	(20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				
HSTA VB NON-MEDICARE RETIREE				
PRESCRIPTION DRUG (provided by CVS Caremark)†				
	In-Network Pharmacy/ Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/ Mail Order**	**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	None			
Day Supply	30/60/90	30/60/90		
Generic	$5/$9/$9	$5/$9/$9 + 30%		
Brand	$15/$27/$27	$15/$27/$27 + 30%		
Insulin	$5/$9/$9	$5/$9/$9 + 30%		
Diabetic Supplies	No charge	No charge		
Specialty Drugs/Injectables	30-day supply only			
	Appropriate drug copays apply			
	Oral oncology: No charge			
	Mail: Not covered			
HSTA VB MEDICARE RETIREE				
EGWP PRESCRIPTION DRUG (provided by SilverScript)†				
	In-Network Pharmacy/ Mail Order	**Out-of-Network Pharmacy††**	**In-Network Pharmacy/ Mail Order**	**Out-of-Network Pharmacy††**
Calendar Year Maximum Out-of-Pocket	None			
Day Supply	30/60/90	30/60/90		
Generic	$3/$9/$9	$3/$9/$9 + 30%		
Brand	$9/$27/$27	$9/$27/$27 + 30%		
Insulin	$3/$9/$9	$3/$9/$9 + 30%		
Diabetic Supplies	No charge	30%		
	Meters: Covered by Medicare Part B and the medical plan	Meters: Covered by Medicare Part B and the medical plan		
Specialty Drugs/Injectables	30-day supply only			
	Appropriate drug copays apply	30%		
	Oral oncology: No charge			
	Mail: Not covered			

* Deductible does not apply.
** Out-of-network benefits are limited to usual customary and reasonable charges.
*** The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.
† Prescription drug benefits are currently provided under separate contracts.
†† Participants will pay full price for the prescription and must file a claim for reimbursement for services received from an out-of-network pharmacy, Participants are responsible for the copayment, including the penalty percentage, and any difference between the actual charge and the eligible charge. These out-of-network costs are not applicable to the annual MOOP. Mail order is not a benefit through out-of-network vendors.

PROPOSAL SHEET 16B – INSURED WITH RISK SHARING
HSTA VB RETIREE 90/10 PPO PLAN

Complete the following table on a monthly per capita tiered basis only. The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount (surplus) will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB Retiree 90/10 PPO Plan	Plan Year 1 1/1/25-12/31/25		Plan Year 2 1/1/26-12/31/26		Plan Year 3 1/1/27-12/31/27		Plan Year 4 1/1/28-12/31/28	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL								
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:								
Self								
Two-Party								
Family								
Monthly Disease Management / Integrated Health Management (DM/IHM) Benefit Cost:								
Self								
Two-Party								
Family								
Monthly Chiropractic Benefit Cost:								
Self								
Two-Party								
Family								
Subtotal Benefit Cost (including Medical, DM/IHM, and Chiropractic):								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):			_____%	_____%	_____%	_____%	_____%	_____%
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Medical Premium (including Benefit Cost, Administration, and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):								
Self								
Two-Party								
Family								
PRESCRIPTION DRUG								
Monthly Prescription Drug Benefit Cost:								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):			_____%		_____%		_____%	
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Prescription Drug Premium (including Administration and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Prescription Drug Premium):								
Self								
Two-Party								
Family								
Disease Management / Integrated Health Management (DM/IHM)								
DM/IHM benefit cost on a PEPM basis:								
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):								
Detailed breakout of the DM/IHM services and costs on a PEPM basis:								

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

Indicate reduction in Medical Retention if the surplus/deficit is carried over to the end of the 4-year contract term: _____%

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 16C – SELF-INSURED ASO
HSTA VB RETIREE 90/10 PPO PLAN

Complete the following table based upon enrollment census and claims assumptions provided.

HSTA VB Retiree 90/10 PPO Plan	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other (including costs for ID cards, wellness, provider directories, SPDs, data reporting, toll-free line, banking, and implementation)				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Self				
Two-Party				
Family				
Estimated Medical Claims Cost:				
Self				
Two-Party				
Family				
Average Discounts				
Average discounts under the proposed networks:	_____%			
Disease Management / Integrated Health Management (DM/IHM)				
DM/IHM benefit cost on a PEPM basis:				
DM/IHM benefit cost on a per engaged member* per month basis (as a replacement to the above):				
Detailed breakout of the DM/IHM services and costs on a PEPM basis:				

***Engaged member should be any member who has received outreach from the carrier.**

Authorized Signature

Title

Name of Company **Date**

PROPOSAL SHEET 17A – PLAN SUMMARY
HSTA VB RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB NON-MEDICARE RETIREE CLOSED PANEL HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50 (in service area)	
	20% (out of service area)	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Visits (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$15 (in service area)	
	20% (out of service area)	
Immunizations	No charge	
	$15 (travel immunizations)	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	$15	
Laboratory and Pathology	$15	
Radiology	$15	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Physical Exam	No charge	
	(age 6 and over)	
Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Well-Child Care Physician Office Visits	No charge	
	(through age 5)	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	50%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home and residential hospice)	
Maternity Care - Routine Prenatal Visits, Delivery, and One Postpartum Visit	No charge (including maternity and newborn inpatient stay)	

PROPOSAL SHEET 17A – PLAN SUMMARY
HSTA VB RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB NON-MEDICARE RETIREE CLOSED PANEL HMO PLAN		PROPOSED BENEFIT DEVIATION	
Chiropractic Services*	$12 (20 visits/CY)			
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic	$10/$20/$30	$10/$20/$20		
Brand	$10/$20/$30	$10/$20/$20		
Insulin	$10/$20/$30	$10/$20/$20		
Diabetic Supplies	50%			
Oral Contraceptives (up to a 12-month supply)	50%			
Specialty Drugs/Injectables	Retail: $10 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: No charge			

* The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

PROPOSAL SHEET 17A – PLAN SUMMARY
HSTA VB RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB MEDICARE RETIREE CLOSED PANEL HMO PLAN	PROPOSED BENEFIT DEVIATION
MEDICAL (provided by Kaiser Permanente)		
	HMO Network	**HMO Network**
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	$2,000 per person	
	$6,000 per family	
Lifetime Benefit Maximum	None	
Inpatient Services		
Inpatient Hospital Services (including room and board and ancillary services)	No charge	
Skilled Nursing Facility	No charge	
	(100 days/benefit period)	
Mental Health Services	No charge	
Emergency Services		
Emergency Room	$50 (worldwide)	
Ambulance (air)	20%	
Ambulance (ground)	20%	
Online Care		
Online Care	No charge	
Physician Services		
Physician Office Visit (including primary care and specialist office visits)	No charge (inpatient)	
	$15 (outpatient)	
Urgent Care	$20 (worldwide)	
Immunizations	No charge	
Surgical Services		
Surgical Procedures	No charge (inpatient)	
	$15 (outpatient)	
Ambulatory Surgical Center (ASC)	$15	
Anesthesia	No charge (inpatient)	
	$15 (outpatient)	
Outpatient Services		
Allergy Testing	$15	
Diagnostic Testing	No charge	
Laboratory and Pathology	No charge	
Radiology	No charge	
Chemotherapy	$15	
Radiation Therapy	$15	
Physical and Occupational Therapy	$15	
Mental Health Services	$15	
Disease Management and Preventive Services		
Annual Wellness Visit	No charge	
Annual Physical Exam	No charge	
Medicare Diabetes Prevention Program	No charge	
Disease Management Programs	$15	
Mammography Screening	No charge	
Preventive Screening Services	No charge	
Other Services		
Advance Care Planning	No charge (Continuing Care)	
Diabetes Equipment	20%	
Durable Medical Equipment	No charge (inpatient)	
	20% (outpatient)	
Hearing Aids	60%	
	(one hearing aid per ear every 36 months)	
Home Health Care	No charge (in service area only)	
Hospice Services	No charge (home hospice only)	
Maternity Care	No charge	
Silver&Fit Healthy Aging and Exercise Program	No charge	
Chiropractic Services**	$12	
	(20 visits/CY)	

PROPOSAL SHEET 17A – PLAN SUMMARY
HSTA VB RETIREE CLOSED PANEL HMO PLAN

Below is a summary of the current plan design and member cost share. A more detailed description of the current benefit plan is provided in Exhibit E, Evidence of Coverage Documents. It will be assumed that the proposed benefits match the current benefits exactly, unless noted otherwise. Note any proposed deviations from the current benefit and provide the rate impact for each proposed deviation, on a tiered basis, as a separate attachment. The Contractor must agree to a "no loss, no gain" provision with the current benefit plan.

Plan Design	HSTA VB MEDICARE RETIREE CLOSED PANEL HMO PLAN		PROPOSED BENEFIT DEVIATION	
Other benefit (not listed above where there is a proposed deviation):				
PRESCRIPTION DRUG (provided by Kaiser Permanente)				
	HMO Network	**Mail Order**	**HMO Network**	**Mail Order**
Calendar Year Maximum Out-of-Pocket	Applies toward the medical MOOP			
Day Supply	30/60/90			
Generic	$10/$20/$30	$10/$20/$20		
Brand	$10/$20/$30	$10/$20/$20		
Insulin	$10/$20/$30	$10/$20/$20		
Diabetic Supplies	20%			
Specialty Drugs/Injectables	Retail: $10 (up to a 30-day supply)			
	Mail: Not all specialty drugs can be mailed			
	Oral oncology: $10			

* The chiropractic benefit is currently administered by American Specialty Health, Inc. and is not applicable to the annual MOOP.

PROPOSAL SHEET 17B – FULLY INSURED
HSTA VB RETIREE CLOSED PANEL HMO PLAN

Complete the following table on a monthly per capita tiered basis only.

HSTA VB Retiree Closed Panel HMO Plan	Plan Year 1 1/1/25-12/31/25		Plan Year 2 1/1/26-12/31/26		Plan Year 3 1/1/27-12/31/27		Plan Year 4 1/1/28-12/31/28	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL AND PRESCRIPTION DRUG								
Monthly Medical Benefit Cost (excluding Chiropractic):								
Self								
Two-Party								
Family								
Monthly Silver&Fit Health Aging and Exercise Program Cost:								
Self	NA		NA		NA		NA	
Two-Party	NA		NA		NA		NA	
Family	NA		NA		NA		NA	
Monthly Prescription Drug Benefit Cost:								
Self								
Two-Party								
Family								
Monthly Chiropractic Benefit Cost:								
Self								
Two-Party								
Family								
Subtotal Benefit Cost (including Medical, Silver&Fit, Prescription Drug, and Chiropractic):								
Self								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Plan Year (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):			_____%	_____%	_____%	_____%	_____%	_____%
Monthly Administration:								
Self								
Two-Party								
Family								
Monthly Retention:								
Self								
Two-Party								
Family								
Total Medical Premium (including Benefit Cost, Administration, and Retention):								
Self								
Two-Party								
Family								
Monthly ACA PCORI Fee (to be added to the above Total Medical Premium):								
Self								
Two-Party								
Family								

Authorized Signature

Title

Name of Company **Date**

ATTACHMENT 10

PBM QUESTIONNAIRE

	Question	Offeror Response
A	**GENERAL INFORMATION**	**Yes / No**
1.	Do you agree that if this proposal results in your company being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in the Proposal Response that any controversy arising over such discrepancy will be resolved in favor of the language contained in the RFP, unless specifically modified by the contract (Y/N)?	
	If No, explain here – 1.	
2.	Do you agree to be bound by the terms of the RFP and your proposal until a final contract is executed (Y/N)?	
	If No, explain here – 2.	
3.	Are there any Special Conditions outlined in Section 1.29 that you cannot meet (Y/N)?	
	If yes, explain here – 3.	
4.	Do you agree to perform all of the services contained in this RFP (including Section IV, Scope of Work, and Section V, PBM Scope of Work), except those specified in Attachment 5, Exceptions (Y/N)?	
	If No, explain here – 4.	
5.	Are all deviations from the requested plan design and coverage (including that of the EGWP) included in the tables in Attachment 9, Plan Summaries and Fee Proposal (Y/N)? If any, attach to your proposal.	
	If No, explain here – 5.	
6.	Does your company, including any affiliates, subsidiaries, or principals of the company, have any pending or has had any legal actions against the State of Hawaii, the EUTF Board, or any EUTF Trustee within the last five years (Y/N)?	
	If yes, explain here – 6.	
7.	Indicate the number of any outstanding legal actions pending against your organization and/or owners. Explain the nature and status of these legal actions. Can you assure the EUTF these actions will not disrupt business operations?	
8.	Describe any and all potential conflicts of interest (e.g. brand manufacturer payments,	

	Question	Offeror Response
	programs that shift prescriptions to more expensive drugs, etc.).	

	Question	Offeror Response
B	**ORGANIZATIONAL DESCRIPTION**	
9.	In the past 24 months, has your organization acquired, been acquired by, or merged with another organization (Y/N)? If yes, explain.	
10.	Is your organization anticipating undertaking any mergers, acquisitions, sell-offs, or change of ownership (Y/N)? If yes, explain.	
11.	In the past 24 months, has your organization restructured or made any major changes to your organization such as staff relocations, member service or claims office closings, or change in computer or phone systems (Y/N)? If yes, explain.	
12.	Is your organization anticipating restructuring or making any major changes to your organization such as staff relocations, member service or claims office closings, or change in computer or phone systems (Y/N)? If yes, explain.	
13.	Provide the following information regarding your organization for CY 2022:	
	a. Total number of covered lives	
	b. Total number of scripts dispensed	
	c. Total AWP dollars processed	
	d. Total number of pharmacy benefit client accounts with over 30,000 covered lives	
	e. Major owners of the organization	
14.	Provide the PBM's book of business turnover rate for the following:	
	a. Overall book of business	
	b. Call center representatives	
	c. Strategic account executives	
	d. Account managers	
	e. Client-facing clinical pharmacists	
C	**ADMINISTRATIVE SERVICES**	
	Account Services	
15.	Do you offer any services with respect to reporting requirements under ACA (Y/N)? If yes, what services do you offer? Confirm that these services will be provided at no additional cost.	
16.	What online services will be made available to EUTF staff? List all that apply. Provide a sample website, login and password if applicable. a. Claims Summary	

	Question	Offeror Response
	b. Billing History c. Premium Rates d. Provider Directory e. Eligibility Summary f. Enrollment Counts g. Plan Details/Benefit Summary (including formulary, required UM criteria, real-time drug pricing, and member cost share) h. Address Changes i. Dummy login to the member portal that can be used throughout the term of the contract j. Other	
17.	What online services will be made available to EUTF members? List all that apply. Provide a sample website, login and password if applicable. a. Claims Summary/EOB b. Billing History c. Provider Directory d. Enrollment Summary e. Plan Details/Benefit Summary (including formulary, required UM criteria, real-time drug pricing, and member cost share) f. Address Changes g. Clinical resources/actionable items to enhance care for patients with chronic and complex conditions h. Other	
18.	Is there a mobile app available for members to access online services?	
19.	Include an explanation of how you fulfill prescriptions for drugs that need refrigeration particularly with respect to residents that may be in rural communities in the state.	
20.	Can you provide a system edit to facilitate physician outreach in order to avoid partial fills (Y/N)? If yes, explain.	
21.	How are services (including refills) provided for members who are travelling domestically or internationally? For an extended period of time (e.g. visiting semester)? For commercial plan members? For EGWP plan members?	
22.	Describe how claims are filled/how your PBM handles drug shortages.	
	Audit Requirements	
23	Do you agree to allow the EUTF the right to audit the performance of the plan and	

	Question	Offeror Response
	services provided as described in Section 4.19, *Audit Requirements* (Y/N)? If yes, indicate what services, records and access will be provided at no additional cost.	
24.	Do you agree to an independent annual audit that measures performance through random sampling (Y/N)? Attach a copy of your audit policy to your proposal.	
25.	Do you agree to provide a comprehensive data file to the auditor that will facilitate electronic analysis with target samples validated through the auditor's review of supporting documentation of sufficient sample size to meet the auditor's requirements to achieve the level of confidence determined by the auditor (Y/N)?	
26.	Confirm your understanding that results from an independent random claims sample will determine compliance with processing performance guarantees.	
27.	Confirm your understanding that non-processing performance guarantees may be validated through an independent audit with such results determining the amount of any penalty due.	
28.	Are you willing to pay an additional penalty amount if the auditor deems there was an error in the self-reported performance guarantee results (Y/N)? If yes, indicate amount.	
	Claims Processing	
29.	Provide the following regarding the claims offices used:	
	a. Location	
	b. Average Claims/Processor/Day	
	c. Annual Claim Volume	
30.	Explain how paper claims are paid. When are they paid based on the submitted rate vs. the contract rate?	
31.	Describe your COB procedures.	
	a. Does COB occur prospectively or retrospectively to payments?	
	b. How often are records updated for new information on other coverage?	
32.	Will you agree to the point of sale coordination (including at mail pharmacy) with other pharmacy benefit plans such that members' out of pocket cost is the net result of the coordination of benefit plans (Y/N)? If yes, how do you ensure proper COB at point of sale?	

	Question	Offeror Response
	For example, do you require periodic pharmacy technician training in provider contracts?	
33.	Describe your appeals process. Include turnaround time to notify member of appeal determination.	
34.	Describe your procedures for recovery of overpayments or duplicate payments. Do you agree to return all recovered monies from overpayments or duplicate payments to client (Y/N)? If no, explain.	
35.	How many subgroup levels can be captured in your claims and billing systems?	
36.	Describe the escalation process for urgent drug claim issues in which a claim is rejected at the pharmacy and members need immediate assistance and resolution.	
37.	Do you have the system capability to capture and support cost share tiers based on diagnosis codes (ICDs) as well as associated claims reporting?	
38.	Do you guarantee that the EUTF will be charged the generic price and the member charged the generic copay if a generic is out of stock or if a house brand is dispensed?	
39.	Can your system identify claims for which a manufacturer copay coupon was used (Y/N)? If yes, can your system restrict these coupons from being used?	
40.	Describe your copayment maximizer program. Indicate any fee and/or cost share associated with such program and any restrictions or client requirements. Confirm that the EUTF qualifies for such a program.	
	Enrollment	
41.	Do you agree to receive and timely and accurately process all of the enrollment and eligibility information in the format as provided by EUTF, without the EUTF making changes to its file format (Y/N)? See Exhibit G, *Sample 834 File*.	
	HIPAA Requirements	
42.	Do you have a formal HIPAA compliance plan in place (Y/N)? If yes, attach a copy to your proposal.	
43.	Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions (Y/N)? If yes, provide the website.	
44.	Where does the copy of your Companion Guide for HIPAA EDI transactions reside?	

	Question	Offeror Response
45.	Will a Notice of Privacy Practices be issued to each new plan enrollee as required by HIPAA (Y/N)? Confirm that these notices will be provided at no additional cost.	
46.	Describe security systems and protocols in place to protect confidential patient records in storage and in transit. Is the site VIPPS certified and licensed in every state?	
47.	What safeguards exist for preventing breaches in patient confidentiality with regard to pharmacy/medical claims information?	
D	**CUSTOMER SERVICES**	
	Call Center	
48.	Provide the following information regarding your local call center for CY 2022:	
	a. Location	
	b. Number of staff	
	c. Days and hours of operation	
	d. Percent of calls abandoned	
	e. Percent of calls handled by a live representative within 20 seconds	
	f. Average number of seconds to reach a live representative	
	g. Number of inquiries made to the call center	
49.	Will dedicated customer service representatives be assigned to this account (Y/N)? If yes, how many at the call center?	
50.	Do customer service representatives have online access to real-time claim status information Y/N)?	
51.	How does your organization accommodate enrollees with special needs? List all that apply. a. No special accommodations b. TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing-impaired c. Contracted independent translation company to accommodate non-English speaking enrollees d. Customer service staff with the ability to translate multiple languages (indicate which languages) e. Other	
52.	Will one toll-free number provide coverage for the retail, mail order, and specialty programs (Y/N)? If not, explain.	
53.	Are all customer service operations requiring verbal communication with the Plan and the	

	Question	Offeror Response
	Plan's members performed in the United States (i.e., will not be provided offshore) (Y/N)?	
	Member Satisfaction	
54.	How are member complaints tracked?	
55.	List the top 5 member complaints. What processes/remedies were put in place to resolve these complaints?	
56.	Do you currently perform member satisfaction surveys? If yes, what percent of members indicated that they were “satisfied” or “very satisfied” with overall plan services? What percent of members indicated that they were “dissatisfied” or “very dissatisfied” with overall plan services?	
57.	Will you survey EUTF members annually to measure enrollee satisfaction as required by Attachment 6, *Performance Guarantees*, at no additional cost (Y/N)?	
	Member Communication	
58.	How will members (including EGWP members) be notified of the following (e.g. phone, mail, etc.):	
	a. Copay structure changes	
	b. Formulary changes such as additions or change in drug tier	
	c. Utilization management changes	
	d. Generic substitution	
	e. Pharmacy network changes	
	f. Ineligible, banned, or recalled drugs	
	g. Nearing Medicare Part D true out-of-pocket limit	
	h. Out-of-stock medications (i.e., in the mobile app)?	
	i. Refills and adherence (include frequency of interventions)	
59.	Describe the process for notifying members of the following:	
	a. Prescriptions not on the formulary	
	b. The expiration date of their prescription	
	c. Their next refill date and the number of refills remaining	
60.	Confirm that the EUTF can customize EGWP member communications at no additional cost when permitted by CMS, unless restricted by federal law.	
61.	Will recovery letters be sent to members who continue to use their drug card after termination at no additional cost (Y/N)? How do you handle amounts owed from members who do not respond?	
E	**FORMULARY**	

	Question	Offeror Response
	Preferred Drug List	
62.	Describe how your preferred drug list is established. Include how specific drugs are selected and how often your P&T Committee meets.	
63.	Are any P&T Committee members employed by or under contract with any drug manufacturers or directly employed by your organization?	
64.	Can custom changes be made to the preferred drug list at the request of the EUTF without impact to financial guarantees (Y/N)?	
65.	How many custom preferred drug lists do you currently support? What percentage of your total member count uses a custom preferred drug list?	
66.	Can a new to market (NTM) block strategy be applied to a custom preferred drug list (Y/N)? If yes, explain and include how NTM drugs would be identified.	
67.	Will you guarantee that any preferred drug list switches which are not economically advantageous to the EUTF on an ingredient cost basis will be reported and reimbursed to the EUTF on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement (Y/N)?	
68.	Do you have a formulary grievance process in place to address member concerns regarding preferred drug list alternatives (Y/N)? If yes, explain.	
69.	Do you have any programs specifically designed to increase formulary compliance (Y/N)? If yes, explain.	
	Non-Preferred Drugs	
70.	Confirm the PBM will allow members to obtain non-preferred drugs with a prior authorization for medical necessity without impacting the rebate guarantees.	
	Compounds	
71.	Describe your system capabilities to process compound claims. Include how compound claims are identified (logic), cost share, contractual discounts, dispensing fees, administrative fees, and rebate guarantees.	
72.	Can you readily provide a detailed listing of all the various ingredients that are included in compound claims and confirm the cost share?	
	Home Infusions	
73.	Describe your system capabilities to process home infusion claims. Include how home infusion claims are identified, cost share,	

	Question	Offeror Response
	contractual discounts, dispensing fees, administrative fees, and rebate guarantees.	
	Vaccines	
74.	How do you adjudicate vaccine claims with or without the associated administration charges from the pharmacy? Specify any limitations (e.g. specific vaccines, need for supplemental pharmacy network, etc.).	
75.	How will your system ensure retail pharmacies will only charge members $0 for ACA and Medicare Part D vaccines?	
76.	Do you offer a vaccine program (Y/N)? If yes, what is the cost for vaccines at participating pharmacies? Include ingredient cost, dispensing fee, associated administration charges from the pharmacy, program fee, and any other cost/fee.	
	Specialty Drugs	
77.	Explain the drug selection process as it pertains to the specialty drug formulary.	
78.	How often does your organization evaluate specialty drug classifications? What is the process that your organization uses to move drugs from a specialty drug classification to a non-specialty drug classification and vice versa? Confirm that the EUTF will be able to reject any changes in such classification.	
79.	Explain any programs offered by your organization designed to encourage appropriate utilization of specialty drug products.	
80.	Will a member incur any additional costs for the delivery of specialty drugs? If so, outline all billing/payment methods and all associated costs.	
81.	Confirm that members will continue to be able to receive specialty prescriptions dispensed at retail pharmacies.	
82.	Confirm that specialty medication utilization will be limited to a 30-day supply.	
83.	What differentiates your company and capabilities from other specialty drug vendors in a very competitive industry? Include any additional services provided when seeing a PBM-owned specialty pharmacy vs. any other specialty pharmacy.	
84.	Provide examples of success with managing specialty costs for other clients.	

	Question	Offeror Response
85.	Do you agree to include a contract provision enabling the EUTF to "carve-out" specialty drug services annually without impact to non-specialty contractual provisions, terms, and pricing (Y/N)?	
86.	EUTF's current specialty carve-out policy allows for specialty drugs administered in a home setting or physician's office to be covered under the prescription drug plan. Confirm that you are able to accommodate this arrangement. Consider in your answer full compliance with Act 226, SLH 2013 and the prohibition of exclusive specialty drug dispensing.	
87.	Provide the customer and enrollee service operation hours of your specialty drug program.	
F	**PHARMACY NETWORK**	
	Provider Directory	
88.	Indicate what is included in your provider directory. List all that apply. a. Pharmacy address and phone number b. Pharmacy hours c. Retail 90 pharmacy designation d. Other	
89.	How often is the network pharmacy directory updated? Is it available online and are hard copies available upon request?	
	Provider Contracting	
90.	Does your organization own any retail network pharmacies, including specialty?	
91.	Are retail and mail order network contracts solely owned and operated by your organization?	
92.	How often are your retail network provider contracts negotiated?	
93.	What percent of your network pharmacy contracts include the "lesser of retail price, MAC price, or discounted price" provision?	

94.	**Provider Terminations**

	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai
Pharmacies						
# of pharmacies that left your network in the past 12 months						
% of pharmacies that left your network						

	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai
Main reason for pharmacies leaving your network (e.g., contract dispute)						

	Question	Offeror Response
	Provider Reimbursement	
95.	Do you maintain multiple contracts with individual pharmacies at varying reimbursement rates (Y/N)? If yes, explain.	
96.	Do your MAC price lists vary contractually between network pharmacies (Y/N)? If yes, explain.	
97.	Describe any incentives or programs in place with providers designed to increase generic dispensing and formulary compliance.	
98.	Is it possible for a retail pharmacy to submit NDC numbers for adjudication that contain AWP prices designed to maximize their discounted ingredient costs?	
99.	Do you receive any financial remuneration that retail pharmacies receive from drug manufacturers or other sources (Y/N)? If yes, describe and include dollar amounts.	
	Pharmacy Audits and Fraud, Waste and Abuse Programs	
100.	Describe how pharmacy errors are captured. List the top 5 reasons for errors (e.g. wrong dosage).	
101.	Describe the process in place to ensure that the EUTF is credited for prescriptions filled but not dispensed (i.e. return to stock situations).	
102.	Describe your quality assurance program and list the most important actions this program has taken in the past year to improve performance.	
103.	Describe your fraud, waste, and abuse program. Include any specific drugs targeted, and how members are notified of the fraud/abuse identified, and describe the resolution process. If there is a formal written program, attach a copy to your proposal.	
104.	Confirm that you will submit all required CMS filings for certification of compliance with all fraud, waste, and abuse requirements.	
105.	Do you monitor individual physician prescribing patterns (Y/N)? If yes, what action is taken with prescribers who have a high degree of non-compliance or outlier prescribing?	

	Question	Offeror Response
	Will you agree to exchange this data with the medical carriers at no additional cost?	
G	**MAIL ORDER PROGRAM**	
106.	Provide the following information regarding the proposed mail order facility for each year in the past three years (2020, 2021, and 2022):	
	a. Mail facility name	
	b. Location	
	c. Days and hours of operation	
	d. Total number of prescriptions dispensed (or scripts filled)	
	e. Utilization as a percent of capacity	
	f. Average turn-around time (no intervention)	
	g. Average turn-around time (intervention required)	
	h. Average generic dispensing rate	
	i. Average generic substitution rate	
107.	Do you agree to have a fully operational mail order fulfillment center in the State by January 1, 2025 (Y/N)?	
108.	Confirm that postage is included in all mail order prescriptions and any mailings.	
109.	Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.	
110.	Does your organization own the mail service facility? If this is a subcontractor, please indicate the subcontractor's name.	
111.	Describe your process for ordering refills by mail, phone, fax, and online. What percentages of refills are currently received by mail, phone, fax, and online?	
112.	Will you agree that all mail order discount guarantees will be based on lowest listed NDC level AWP cost (Y/N)?	
113.	What is the average time in calendar days between receipt of claim and delivery to patient (include delivery time)? When a Hawaii facility is used? When a non-Hawaii facility is used?	
114.	Confirm that the EUTF will not be charged for uncollected mail order cost share amounts.	
115.	Does your organization, or your associated facilities, repackage drug products for use in filling mail order prescriptions? If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler? If not, describe how you establish the AWP for your repackaged NDCs.	

	Question	Offeror Response
116.	Explain the process for providing members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription.	
117.	How are members notified when a mail order prescription is delayed due to the following circumstances:	
	a. A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name)	
	b. A clean prescription where the delay is due to operational, capacity, or drug supply issues	
	c. A clean prescription where the delay is a result of a therapeutic switch intervention	
	d. Weather or natural disaster	
	e. Other	
118.	Indicate your mail order pharmacies' usage, if any, of DAW 5 for processing claims. Which drug products are assigned DAW 5 codes? Describe your DAW 5 processing protocol and rationale.	
119.	Describe any additional service or value benefits provided by your mail order service pharmacies.	
120.	Will you agree to hold EUTF harmless for any claims resulting from dispensing errors from mail order fulfillment?	
121.	Describe how refrigerated medications are mailed.	
122.	Describe how members would be assisted in transferring prescriptions from retail to mail order.	
H	**CLINICAL PROGRAMS**	
123.	Confirm disease and therapy management programs you offer are included in your base administrative fee (Y/N).	
124.	Does your organization currently engage in outcomes reporting (Y/N)? If yes, explain.	
	Drug Utilization Review	
125.	Provide the book of business savings as % of total ingredient costs in the last quarter for the following programs: a. Concurrent DUR b. Retrospective DUR c. Prior authorization	
126.	Are reported savings based on an EUTF specific claim-by-claim analysis? If no, describe the savings calculation process for each of the claim edit services you offer.	

	Question	Offeror Response
127.	How are high-cost claimants identified and monitored? Do you offer any programs to mitigate the cost of these claims? If yes, include any additional cost for such programs.	
128.	Describe your prior authorization protocols, including any automation or "smart" capabilities (i.e. integration with Step edits). Include information on step therapies, other clinical management programs, any additional cost for such programs, and credentials of staff providing the prior authorization.	
129.	How do you provide notification of a product recall to the EUTF and its members?	
130.	Describe the PBM's capabilities to use medical claims data and prescription claims data to identify safety and health risks.	
131.	Confirm the PBM will not charge more than once for a Prior Authorization fee for a single prescription (e.g., the PBM won't charge multiple times if they have to reach out to the doctor multiple times for a single prescription).	
132.	Describe the PBM's programs to better manage the high cost of Diabetes, Anti-Inflammatory (including dermatologics and anti-arthritics), and Oncology drugs.	
133.	Confirm the PBM will exclude non-FDA approved drugs.	
134.	Describe how the PBM will manage DESI drugs.	
135.	Describe the PBM's process to better manage drug inflation.	
136.	Describe the PBM's programs to better manage high-cost non-specialty generics and brands as well as hyperinflation drugs. Does the PBM guarantee to refund the EUTF for every non-specialty drug over $1,000 that adjudicates that was not properly reviewed by the PBM?	
I	**EMPLOYER GROUP WAIVER PLANS**	
137.	Provide the proposed EGWP CMS Star Rating for each year in the past three years (2020, 2021, and 2022).	
138.	Describe any corrective action taken in the past three years to improve the proposed EGWP CMS Star Rating.	
139.	How many EGWP clients do you currently have? Provide the average number of covered lives for your top 10 EGWP clients.	
140.	Describe your capabilities to provide a secondary commercial wrap benefit to the	

	Question	Offeror Response
	EGWP in order to maximize the pharmaceutical manufacturers coverage gap discount program (CGDP).	
141.	Confirm that your P&T Committee meets CMS requirements for objectivity and validity.	
142.	Confirm that you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis.	
143.	Confirm that you will provide separate reporting and billing for the EGWP group.	
144.	Confirm you will process low-income subsidy (LIS) refunds to members and the EUTF as well as low-income cost sharing refund requests to the members.	
	EGWP Enrollment	
145.	Describe the enrollment/disenrollment process and include the timing of when enrollment changes go into effect. How do you handle the CMS required "opt hold" period such that there is the least amount of benefit disruption to the member if the EUTF notifies you retroactively within 30 days of Medicare enrollment?	
	EGWP Formulary	
146.	Describe the transition process you will utilize for members who are currently using non-formulary prescription drugs, drugs requiring prior authorization, step therapy, and quantity level limits.	
J	**FINANCIAL TERMS**	
147.	Confirm there will not be any additional charges if plans/benefits are restructured or new classes of eligible members are added (Y/N).	
148.	Confirm drug data compendia used is MediSpan, including drug type designation (e.g. brand or generic) and AWP.	
149.	Do you agree to provide upon request any proprietary algorithm, hierarchy or other logic employed to define a prescription drug as brand or generic (Y/N)?	
150.	Confirm Network pharmacies will charge members the lowest of the discounted plan cost plus dispensing fee, member copay, MAC, U&C or retail price and Members will pay the lowest of the discounted plan cost plus dispensing fee, member copay, MAC, U&C or retail price (Y/N).	
151.	Confirm the PBM will only charge a fee (e.g., administrative fee or dispensing fee) for Paid Claims and will not charge a fee for reversals,	

	Question	Offeror Response
	rejected claims, adjustments or reprocessed claims.	
	Non-Rebate Pricing Guarantees	
152.	Confirm a drug would be considered new to market (NTM) for no longer than 6 months in order to be discounted under the specialty OED guarantee (Y/N).	
153.	Confirm discount guarantees are not subject to exclusive/mandatory networks including mail and specialty (Y/N).	
	Rebate Guarantees	
154.	Confirm that the greater of minimum guarantee rebates and 100% of actual received rebates will be passed through to the EUTF.	
155.	Do you receive formulary rebates from manufacturers of generic or biosimilar drugs (Y/N)? If yes, confirm that these will be paid to the EUTF.	
156.	Do you use an external rebate aggregator (Y/N)? If yes, which one?	
157.	Confirm rebate guarantees are not dependent on adoption of standard formulary and/or UM criteria (client may opt out of changes) (Y/N)?	
158.	12. Confirm rebate guarantees are not dependent on adoption of clinical programs and/or services (Y/N)?	
K	**REPORTING**	
159.	Describe your methodology to report outcomes for core clinical programs and non-core (buy-up) programs.	
160.	What benchmarks will be used when comparing our utilization and cost data?	
L	**SURPRISE BILLING AND TRANSPARENCY RULE**	
161.	Describe how your company will assure that the EUTF is in compliance with federal law and regulations concerning surprise billing and transparency with respect to the services provided by your company.	
162.	List any subcontractors or third-parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the EUTF.	
163.	List any technical specifications that the EUTF will need to meet to use any solution you intend to offer to comply with the law and regulations, including software, hardware, or other information technology.	

	Question	Offeror Response
164.	Are you fully compliant with the law and regulations by the statutory and regulatory due dates? If not, please explain.	
165.	Are the fees you propose inclusive of all services related to the law and regulations? If not, please explain what additional costs the EUTF may incur.	
166.	Will you provide the EUTF with the negotiated rates and historical net prices for covered prescription drugs in a machine-readable file to the extent the Departments issue regulations and/or guidance requiring group health plans to post this information on a public website?	
	a. Describe the information technology requirements necessary for transmitting files and/or posting them.	
	b. Will you send information to the EUTF or provide another service to the EUTF that allows the EUTF to link you another website?	
167.	Do any contracts you are a party to contain a claim prohibiting disclosure of pricing terms (“gag clause”) which is prohibited under the Consolidated Appropriations Act (CAA), 2021?	
	a. If yes, please describe and state how you will assure they are removed. Indicate your timeline for removing gag clauses from contracts.	
	b. On behalf of the EUTF, will you attest to not having gag clauses in applicable contracts and submit the attestation to the Departments in a timely manner?	
168.	If you are providing any preferred Network providers, describe communications you have made to Network providers concerning the Act.	
	a. Describe any provider or facility billing processes adopted or changed to comply with the No Surprises Act.	
169.	The Act requires ID cards to contain information about deductibles and out-of-pocket maximums.	
	a. Have you updated your ID cards to include at a minimum the major medical deductible and out-of-pocket maximum; a telephone number and internet website address for participants to seek consumer assistance, and access additional	

	Question	Offeror Response
	applicable deductibles and maximum out-of-pocket limits?	
	b. Please provide a copy of a template ID card.	
170.	For grandfathered and non-grandfathered plans, please describe how you will support the additional External Appeals requirements for Covered Services? Do you provide a contract with an Independent Review Organization for external review?	
171.	If you provide a preferred provider network, describe your process for allowing continuation of care for individuals when their health care provider is terminated from the Network, under ERISA Section 718 and PHSA Section 2799A-3.	
	a. Describe how patients are protected from being billed at an out-of-network rate and how the patient is provided with notice under the law.	
172.	Do you provide a price comparison tool via an internet website, via telephone, and in paper form upon request, that allows a participant to compare the amount of cost sharing that they will be responsible for by participating provider and geographic region?	
	a. Will your price comparison tool include all items and services by January 1, 2025?	
	b. Describe the price comparison tool in detail, and whether any subcontractors are used to produce it.	
	c. Describe who will provide the telephone tool and at what location.	
	d. Is there a dedicated team for the EUTF's participants to provide the tool and assist with its use?	
	e. What internet website will be used for the price comparison tool, and will the EUTF need to provide its own website to link to the tool or will your company provide that site?	
	f. What is the source of the rate information provided by the tool?	
	g. With which benefits software vendors is your tool integrated?	
	h. Describe what, if any, features are available beyond the requirements of the No Surprises Act. Is the EUTF able to opt out of any such features?	
	i. Describe any additional costs for the tool.	

	Question	Offeror Response
173.	Describe your process for addressing participant or provider complaints that may be made against the EUTF under the Act.	
174.	The following questions seek to confirm how you will assist the EUTF in annually reporting prescription drug and total health claim costs and other information to the federal government (i.e., RxDC reporting requirements).	
	a. Describe your process for reporting prescription drug and total health claim cost information to the federal government.	
	b. On behalf of the EUTF, will you submit to the Departments each of the following files on an aggregated basis, including the cost data of the EUTF? If not, please indicate which you will not submit.	
	i. P2 File	
	ii. D1 File	
	iii. D2 File	
	iv. D3 File	
	v. D4 File	
	vi. D5 File	
	vii. D6 File	
	viii. D7 File	
	ix. D8 File	
	c. If you will submit on an aggregated basis including EUTF data, what information will the EUTF need to provide? Please describe your process for gathering any such information, including any technology specifications.	
	d. If you will submit on an aggregated basis including EUTF data, will you provide confirmation of timely submission to the EUTF? Will you provide a copy of your submission to the EUTF?	
	e. If you will not submit on an aggregated basis including EUTF data, will you provide cost data to the EUTF sufficient for the EUTF to submit the required reporting? In what format will the cost information be provided?	
	f. Describe whether you will accept responsibility for fulfilling all cost reporting obligations and if not which ones you will not fulfill.	

	Question	Offeror Response
	g. State any additional costs for this reporting service.	

ATTACHMENT 11

PBM PROPOSAL

Complete the following tables on a dollar-for-dollar basis. AWP discount guarantees must be a discount from 100% AWP and based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback. The Offeror agrees that these guarantees are based on the EUTF's current open formulary, covered prescription drug, and utilization management programs (including prior authorizations and quantity limits); and no additional prescription drugs will be excluded or utilization management programs added or enhanced without the prior approval of the EUTF Board.

Actives	**Plan Year 1 7/1/25-6/30/26**	**Plan Year 2 7/1/26-6/30/27**	**Plan Year 3 7/1/27-6/30/28**	**Plan Year 4 7/1/28-6/30/29**
Administrative Fee (per employee per month)				
Electronic Claim				
Manual Claim				
AWP Discount Guarantees				
Retail 30 (up to 83-day supply)				
Brand				
Generic				
Retail 90 (84-90 day supply)				
Brand				
Generic				
Mail (up to 90-day supply)				
Brand				
Generic				
Specialty OED Guarantees				
Retail 30 (up to 83-day supply)				
Specialty Brand				
Specialty Generic				
NTM Specialty (including LDD and biosimilars)				
PBM Specialty Pharmacy (up to 30-day supply)				
Specialty Brand				
Specialty Generic				
NTM Specialty (including LDD and biosimilars)				
Dispensing Fee Guarantees (per prescription dispensed)				
Retail 30				
Retail 90				

Actives	Plan Year 1 7/1/25-6/30/26	Plan Year 2 7/1/26-6/30/27	Plan Year 3 7/1/27-6/30/28	Plan Year 4 7/1/28-6/30/29
Mail				
Specialty				
Rebate Guarantees (per brand claim)				
Retail 30				
Retail 90				
Mail				
Specialty				
LDD				
List any exclusions from specialty rebate guarantees.				

Non-Medicare Retirees	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
Administrative Fee (per retiree per month)				
Electronic Claim				
Manual Claim				
AWP Discount Guarantees				
Retail 30 (up to 83-day supply)				
Brand				
Generic				
Retail 90 (84-90 day supply)				
Brand				
Generic				
Mail (up to 90-day supply)				
Brand				
Generic				
Specialty OED Guarantees				
Retail 30 (up to 30-day supply)				
Specialty Brand				
Specialty Generic				
NTM Specialty (including LDD and biosimilars)				
PBM Specialty Pharmacy (up to 30-day supply)				
Specialty Brand				
Specialty Generic				
NTM Specialty (including LDD and biosimilars)				
Dispensing Fee Guarantees (per prescription dispensed)				

Non-Medicare Retirees	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
Retail 30				
Retail 90				
Mail				
Specialty				
Rebate Guarantees (per brand claim)				
Retail 30				
Retail 90				
Mail				
Specialty				
LDD				
List any exclusions from specialty rebate guarantees.				

EGWP	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
Administrative Fee (per retiree per month)				
Electronic Claim				
Manual Claim				
AWP Discount Guarantees				
Retail 30 (up to 83-day supply)				
Brand				
Generic				
Retail 90 (84-90 day supply)				
Brand				
Generic				
Mail (up to 90-day supply)				
Brand				
Generic				
Specialty OED Guarantees				
Retail 30 (up to 83-day supply)				
Specialty Brand				
Specialty Generic				
NTM Specialty (including LDD and biosimilars)				
PBM Specialty Pharmacy (up to 30-day supply)				
Specialty Brand				
Specialty Generic				

EGWP	Plan Year 1 1/1/25-12/31/25	Plan Year 2 1/1/26-12/31/26	Plan Year 3 1/1/27-12/31/27	Plan Year 4 1/1/28-12/31/28
NTM Specialty (including LDD and biosimilars)				
Dispensing Fee Guarantees (per prescription dispensed)				
Retail 30				
Retail 90				
Mail				
Specialty				
Rebate Guarantees (per brand claim)				
Retail 30				
Retail 90				
Mail				
Specialty				
LDD				
List any exclusions from specialty rebate guarantees.				

Exclusions

Indicate if the following products are included or excluded:

	Discount and Dispensing Fee Guarantees		Rebate Guarantees	
	Included	**Not Included**	**Included**	**Not Included**
Compounds				
340b pharmacy claims				
Out of network claims				
Paper submitted claims				
Secondary payor claims (COB or subrogation)				
Vaccines				
Non-blood glucose/diabetic test strip over the counter (OTC) products				
Blood glucose/diabetic test strips				
Lipid disorder – PCSK9 products				
Long term care (LTC)				
Home infusion				
Indian health services and tribal claims				
Ancillary supplies				
Over the counter (OTC) claims				

GDR Guarantees - Commercial

GDR Guarantees	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
Retail 30				
Retail 90				
Mail				

GDR Guarantees - EGWP

GDR Guarantees	Plan Year 1	Plan Year 2	Plan Year 3	Plan Year 4
Retail 30				
Retail 90				
Mail				

What maximum annual dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?
Actives:
Non-Medicare Retirees:
EGWP:

Inflation Cap Guarantee
Describe any price inflation guarantee you are willing to put forth for non-specialty and/or specialty products.

Administrative Fees
Complete the following Administrative Fee table. Indicate if the following services are included in the Administrative Fee. If not, indicate the additional cost. Include as a separate attachment, a list of services not included in the table below that are 1) guaranteed in the Administrative Fee and 2) not guaranteed in the Administrative Fee. Provide details.

Service	Included	Not Included	Additional Cost
Account management			
Audit recovery fees			
COB program			
Compound drug management			
Custom system overrides			
ePrescribing fees			
Formulary administration/management/print			
Group coding			
Mail program			
Network management			
Pharmacy auditing			
Specialty drug program			
Toll free phone lines			
Monthly data feeds to the EUTF or designee(s); including daily exchange of			

Service	Included	Not Included	Additional Cost
out-of-pocket information with medical vendor			
SPDs and SBCs			
Claim Forms			
Other			
Appeals			
Standard 1st level appeals processing			
Standard 2nd level appeals processing			
Urgent appeals processing			
Overrides			
Urgent appeal service for utilization management, formulary, and benefit reviews			
Member communication			
Explanation of Benefits (EOB) statements (monthly)			
ID cards (including postage)			
Member notification letters			
Edits to member notification letters			
Member satisfaction surveys			
Pharmacy directories and other member materials			
Retro termination letters			
Reports			
Standard reports			
Ad hoc reports			
RxDC file submission			
Utilization management programs			
Dose optimization program			
Opioid management fees			
Prior authorization program			
Quantity limits			
Step therapy program			
Utilization management fees			
Clinical programs			
Prospective/concurrent/retrospective drug utilization review (DUR)			
Safety and monitoring			
Additional EGWP services			
Collect and validate Medicare HICN			
Benefit consultation and actuarial equivalence validation			
Monitor and track all CMS changes			

Service	Included	Not Included	Additional Cost
CMS required member communication (including Evidence of Coverage and Annual Notice of Changes)			
Research and resolve enrollment errors			
Enrollment modifications resulting in low-income assistance as granted or removed by CMS			
Full enrollment reports (accepted, rejected, or CMS changes)			
Collect late enrollment penalties and remit to CMS			
Fraud, waste and abuse program			
Grievance, appeals, and coverage determination – investigate and resolve complaints from the CMS Complaint Tracking Module			
ID card/abridged formulary/pharmacy directory			
Medication therapy management (MTM) program			
Transition letters			
Manage TrOOP			
Low-Income Subsidy (LIS) Rider			
LIS premium refunds directly to low-income retirees			
Receive and reconcile CMS Direct Subsidy (paid 45 days after receipt), LIS, LICS (paid at time or reconciliation) and Catastrophic Payments (paid at time of reconciliation)			
Reconcile LIS eligibility with CMS (monthly)			

Guaranteed Contract Credits

1. General Administrative Credit. If you agree to provide a General Administrative Credit, provide the annual dollar amount you are offering the EUTF for general expenses related to the management of the pharmacy benefits program such as communication expenses, clinical programs, or consulting fees. Any remaining credit amount at the end of the contract period may be used against claim invoices, pharmacy audits, or pharmacy benefit consultant services. Indicate whether the EUTF will be able to rollover any unused amount to the next contract year.
2. Developmental Credit. If you agree to provide a Developmental Credit, provide the annual dollar amount you are offering the EUTF for clinical program expenses, including clinical programs provided under the medical plan. Indicate whether the EUTF will be able to rollover any unused amount to the next contract year.

EXHIBIT A

CLAIMS EXPERIENCE

Claims data will be provided upon completion of Attachment 2, *Intent to Bid Form* and signed Attachment 3, *Confidentiality Agreement*.

EXHIBIT B

PREMIUM RATES

Premium rates are available at the EUTF website:
http://eutf.hawaii.gov/

EXHIBIT C

EUTF ADMINISTRATIVE RULES

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

ADMINISTRATIVE RULES

CONTENTS

1.00 GENERAL PROVISIONS

1.01 Purpose

Chapter 87A of the Hawaii Revised Statutes establishes a health trust fund known as the Hawaii Employer-Union Health Benefits Trust Fund. The Fund is to be used to provide eligible state and county employees, retirees, and their dependents with health and other benefit plans at a cost affordable to both the public employers and the public employees. The board is to administer and carry out the purposes of the Fund. These rules are adopted by the board pursuant to Section 87A-26 of the Hawaii Revised Statutes to implement the administration and purposes of the Fund.

1.02 Definitions

As used in these rules, unless otherwise indicated by the context, the following terms shall have the following meanings:

"Administrator" means the administrator of the Fund appointed by the board or the duly authorized representative of the administrator.

"Benefit plan" means a health benefit plan, a group life insurance plan that is subject to Section 79 of the Internal Revenue Code, or any other type of benefit plan except for a long-term care benefit plan.

"Board" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Cancellation Non-Payment Status" means an employee-beneficiary whose plans have been cancelled for the remainder of the plan year due to failure to pay the required semi-monthly or monthly contributions.

"Carrier" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Child" means an employee's, spouse's or partner's as defined in these rules, legally adopted child, child placed for adoption, stepchild, foster child, or recognized natural child but excluding a child born or legally adopted more than ten months after the date of death of: (1) an active employee killed in the performance of duty; (2) an active employee who was eligible to retire on the date of death; or (3) a retired employee-beneficiary. For non-excepted benefits, a child may be unmarried or married and does not need to live with or be financially dependent on the employee-beneficiary. For excepted benefits, a child must be unmarried and live with the employee-beneficiary. A child has been placed for adoption when an employee-beneficiary, spouse, or partner has assumed custody of and the obligation to support a child in anticipation of adopting the child. A foster child is a child: (1) who lives with an employee in a regular parent-child relationship; and (2) for whom the employee has become the child's guardian and has been awarded legal and physical custody of the child pursuant to a valid court order.

"Civil Union Partner" means an individual who is a party to a civil union established pursuant to Chapter 572B of the Hawaii Revised Statutes.

"Contribution" or "Contributions" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"County" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Dependent-beneficiary" shall mean the persons described in Rule 3.01 of these rules as being eligible for coverage as dependent-beneficiaries in the health benefit plans offered or sponsored by the Fund.

"Dissolution of domestic partnership" shall occur when: (1) the employee-beneficiary no longer meets the requirements to qualify as a "domestic partner"; (2) one of the partners to the domestic partnership expressly informs the other of the end of their domestic partnership; (3) one of the partners to the domestic partnership takes actions inconsistent with the continued existence of the domestic partnership; or (4) the domestic partnership is otherwise terminated or dissolved.

"Domestic partner" shall mean a person in a spouse-like relationship with an employee-beneficiary who meets the following requirements: (1) the employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely; (2) the employee-beneficiary and the domestic partner have a common residence and intend to reside together indefinitely; (3) the employee-beneficiary and the domestic partner are and agree to be jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care; (4) neither the employee-beneficiary nor the domestic partner are married or a member of another domestic partnership; (5) the employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii; (6) the employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract; (7) the consent of the employee-beneficiary or the domestic partner to the domestic partnership has not been obtained by force, duress or fraud; and (8) the employee-beneficiary and the domestic partner sign and file with the Fund a declaration of domestic partnership in such form as the board shall from time to time prescribe.

"Eligibility" shall have the meaning as meeting the Fund's requirements to participate or be qualified to participate in plans offered by the Fund.

"Employee" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Employee-beneficiary" shall mean the persons described in Rule 3.01 of these rules as being eligible to enroll as employee-beneficiaries in the health benefit plans offered or sponsored by the Fund.

"Employer" or "public employer" shall have the meaning as set forth in Section 89-2 of the Hawaii Revised Statutes.

"Excepted Benefits" shall mean benefits not subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of 'excepted benefits' include stand alone dental and vision plans and retiree-only plans.

"Fraud and Intentional Misrepresentation" includes, but is not limited to, intentionally or knowingly keeping an ineligible dependent enrolled in a Fund benefit plan (for example, an ex-spouse, over age or ineligible dependent child, etc.). Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage in a Fund benefit plan, or filing fraudulent claims as described in Rule 4.12(b). The Fund will provide at least thirty (30) days advance written notice to each participant who will be affected before coverage is rescinded for fraud or intentional misrepresentation. In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Fund.

"Full-time student" means a student who is enrolled in an accredited school, college, or university for not less than the minimum number of credit hours required by such educational institution to have full-time student status.

"Fund" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Fund benefit plan" means a benefit plan offered or sponsored by the Fund.

"Health benefit plan" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Limiting Age" shall mean: (1) for active employees, pertaining to excepted benefits, as defined in this Rule 1.02, the age a child loses

eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (2) for active employees, pertaining to non-excepted benefits, as defined in this Rule 1.02, the age at which a child loses eligibility as a dependent-beneficiary is upon the end of the month that the dependent reaches age twenty-six; (3) for retirees, surviving spouses and surviving partners, the age a child loses eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (4) for an unmarried child of (a) an employee who is killed in the performance of the employee's duty or (b) deceased retired employee and does not have a surviving parent who is eligible to be an employee-beneficiary, the age a child loses eligibility is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1,02, which would extend the limiting age to the child's twenty-fourth birthday.

"Non-excepted Benefits" shall mean benefits subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of non-excepted benefits include medical and prescription drug plans for active employees.

"Month" shall mean thirty (30) days.

"Non-Fund benefit plan" means a benefit plan offered or sponsored by a private employer or an entity other than the Fund.

"Part-time, temporary, and seasonal or casual employee" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Partner" or "Partnership" shall mean a domestic partner or civil union partner.

"Periodic change" shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Plan year" shall mean the 12-month period from January 1 through December 31 for retired employees and July 1 through June 30 for active employees.

"Qualified-beneficiary" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Qualified medical child support order" means any judgment, decree, or order issued by a court of competent jurisdiction that requires the provision of health benefits coverage to a child of a non-custodial parent.

"Retired member" or "retired employee" means a former employee, officer, appointed or elected official of the State or counties who is currently receiving a retirement or pension allowance from a State or county retirement system or an employee who retired prior to 1961.

"Spouse" means a person who is lawfully married pursuant to Hawaii law".

"State or county retirement system" means the employees' retirement system, the county pension system, or the police, fire, or bandsmen pension system of the State or any county.

"Termination of civil union partnership" means the civil union partnership terminates in accordance with applicable state laws and rules.

"Trustee" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

"Trustee group" means the group composed of the five trustees representing public employers or the group composed of the five trustees representing employee-beneficiaries as described in Section 87A-5 of the Hawaii Revised Statutes.

1.03 Public Information

To the extent permitted by applicable federal or state law, the public records of the Fund shall be available for inspection at the Fund's office during regular business hours. All requests for inspection of public records shall be in writing and addressed to the administrator or any other person designated by the board to receive such requests. Copies of public records shall be provided upon the payment of the reasonable costs of reproduction and any fees for searching, reviewing and segregating such records. The board shall establish such costs and fees in accordance with applicable federal and state law.

Protected health information about employee-beneficiaries and dependent-beneficiaries are not public records. Employee-beneficiaries, dependent-beneficiaries, and others may have access to such information only in conformance with the Health Insurance Portability and Accountability Act of 1996 and the rules passed under that Act ("HIPAA"), and the Fund's HIPAA Privacy Policies and Procedures.

1.04 Computation of Time

Whenever a period of time is stated in these rules as a number of days from or after an event: (a) the period shall be computed in calendar days; (b) the day of the event shall not be included in the calculation; and (c) the last day of the period shall be included in the calculation.

1.05 Officers of the Board

(a) The board shall elect a chairperson, vice-chairperson, and secretary-treasurer.

(b) Both the chairperson and vice-chairperson shall be elected from the same trustee group. The secretary-treasurer shall be elected from the other trustee group.

(c) Officer terms shall be for one year beginning July 1, 2002, and shall rotate between the trustee groups annually. The terms of all elected officers shall terminate on June 30 of each succeeding year and such officers shall vacate their offices at that time.

(d) Except as otherwise provided by law or by rules or policies adopted by the board, the duties of the officers shall be as provided in the current version of *Robert's Rules of Order, Newly Revised.*

(e) The chairperson or vice-chairperson and secretary-treasurer shall coordinate assignments to the administrator and other Fund staff, requests for information, and other matters concerning the administration and operation of the board.

1.06 Committees of the Board

(a) Standing committees shall be established by the board to address critical issues in the major functional areas of the Fund:

(1) The Administrative Committee will have combined administrative and finance committee functions;

(2) The Benefits Committee will have benefits and communication committee functions.

(3) The Investment Committee will review the reports of the Investment Consultant and report to the Board of Trustees on the Fund's investments.

(b) The board may establish other committees to address matters related to the operation or administration of the Fund or to investigate issues that impact the Fund.

(c) Committees shall operate informally and shall make recommendations to the full board. Meetings of all standing committees will comply with Part I of Chapter 92 of the Hawaii Revised Statutes.

(d) A minimum of four trustees (two trustees from each trustee group) shall be assigned to a committee. The assigned number of trustees may be larger for certain committees provided that an equal number of trustees are assigned from each trustee group.

(e) Attendance of at least one trustee from each trustee group shall be necessary to convene a committee meeting.

(f) Committees may select a chairperson and any other officers as deemed necessary by the board.

(g) Committee chairpersons shall coordinate assignments to the administrator and other Fund staff for their respective committees.

(h) Trustees in attendance shall agree within their working committees on recommendations made to the full board. When there is no agreement by the trustees in attendance, the committee shall present a summary of the disagreement(s) to the full board.

1.07 Meetings of the Board

(a) To the extent permitted by applicable federal or state law, the meetings of the board shall be open to the public. Without limiting the foregoing, board meetings shall comply with Part I of Chapter 92 of the Hawaii Revised Statutes, including the provisions therein requiring: (1) written and electronic notice of board meetings at least six days prior to each meeting; and (2) written minutes.

(b) The board shall designate the administrator or some other member of the Fund's staff to be responsible for preparing agendas for future board meetings. Any trustee may place a question or subject on the agenda of a future board meeting by notifying the administrator or other designated staff person by 12:00 noon, seven days prior to the board meeting. All board meeting agendas shall be transmitted to the chairperson for review prior to public notice.

(c) Unless otherwise required by the board or applicable law, the parliamentary procedure to be used by the board in the conduct of its meetings shall be in accordance with the current version of *Roberts Rules of Order, Newly Revised.*

(d) Voting procedures for board meetings and the criteria for a quorum are established in Section 87A-11 of the Hawaii Revised Statutes. In addition, the following voting procedures shall apply:

(1) After a motion is made and seconded, the presiding officer shall read the motion and open the question to discussion and debate by the trustees. When ready to put the motion to a vote, the presiding officer shall call for the public employer and employee-beneficiary

trustee votes to determine whether there are three votes from each trustee group in favor of the motion. If so, the motion shall be recorded as having been approved by one vote from the public employer trustees and one vote from the employee-beneficiary trustees.

(2) For routine or procedural matters, the presiding officer may ask if there is any opposition to a motion after it has been made, and to the extent required, seconded and debated. If no opposition is voiced, the motion shall be recorded as having been unanimously approved by one vote by the public employer trustees and one vote from the employee-beneficiary trustees.

(3) If the voting is not unanimous by each side, the names of the trustees who voted in favor of the motion, voted against the motion, or abstained from voting shall be recorded in the minutes.

(4) In the event of a deadlock in the vote of the board, the board may vote on the same question or resolution at the next two successive meetings of the board. In the event of a deadlock in the vote of the board on the same question or resolution at the two successive meetings of the board, the board shall vote on whether or not to engage in dispute resolution. If six trustees of the board vote to engage in dispute resolution, the two trustee groups shall enter into mediation to attempt to resolve the question or resolution upon which the board has deadlocked.

The mediation shall be handled by a mediator appointed by the Federal Mediation and Conciliation Service. If the Federal Mediation and Conciliation Service fails or refuses to appoint a mediator within ten (10) days of the date on which the six trustees voted to engage in dispute resolution, the mediation shall be handled by a mediator mutually agreeable to the two trustee groups. If the two trustee groups do not agree on a mediator within twenty (20) days of the date on which the six trustees voted to engage in dispute resolution, either trustee group may petition the Administrative Judge of the First Circuit, Circuit Courts of the State of Hawaii, to appoint a mediator. Upon the appointment of a mediator, the two trustee groups shall in good faith enter into mediation on the question or resolution upon which the board has deadlocked. Nothing in this rule is meant to preclude the board

from voting to engage in other forms of alternate dispute resolution to resolve a question or resolution upon which it has deadlocked.

(5) Whenever any statute or other law requires a vote of a majority, two-thirds or other percentage or fraction of the trustees or members to which the board is entitled, the motion or other action shall be approved if it receives two votes in favor of the motion or action as provided in subsection (d)(1) of this Rule, regardless of the total number of votes in favor of the motion or action.

For example, if a statute or other law requires a two-thirds vote of the members to which the board is entitled, the motion or other action will be approved if three trustees from each trustee group vote in favor of the motion or other action, even if the remaining four trustees vote against the motion or other action.

1.08 Appearances Before the Board

(a) All persons shall comply with this rule when appearing before the board. Unless otherwise required by applicable federal or state law, the board shall have the discretion to prescribe additional standards and procedures for all appearances and proceedings before the board. The board may waive or suspend the provisions of this rule with respect to any particular appearance or proceeding before it.

(b) Any person appearing before the board may appear in person, by an officer, partner or regular employee of the party, or be represented by an authorized representative. The board may at any time require any person transacting business with the board in a representative capacity to prove or authenticate the person's authority and qualification to act in such capacity.

(c) The board shall afford all interested persons an opportunity to present oral testimony or submit data, views, or arguments, in writing, on any agenda item.

(1) Persons providing written testimony shall provide thirty copies of their testimony of which twenty (20) copies shall be made available to the public. Twenty (20) copies of materials provided to the board for or during a meeting that are determined to be disclosable shall be made available for distribution to the public.

(2) The board shall hear oral testimony on an agenda item after it has completed discussion of that item. At that time, the presiding officer shall invite members of the public to ask questions or provide comments on the agenda item prior to any action by the board. After the public has had an opportunity to provide input on the agenda item, the board may discuss the agenda item further and act on the item or move on to the next agenda item.

(3) A person may speak at a board meeting only when recognized to do so by the presiding officer. Comments are limited to three minutes per speaker. Time limitations may be adjusted at the discretion of the presiding officer or at the request of any three trustees. A person may not speak a second time on the same question unless authorized by the presiding officer to do so.

(4) The board may refuse to hear any testimony that is irrelevant, immaterial, or unduly repetitious and may from time to time impose additional conditions as are necessary or desirable for the orderly, efficient, and convenient presentation of oral testimony to the board. The board may request that the person providing oral testimony submit the testimony in writing to the board.

(d) Nothing herein shall require the board to hear or receive any oral testimony or documentary evidence from a person on any matter which is the subject of another proceeding pending before the board.

1.09 Delegation of Authority

To the extent permitted by law, the board may delegate authority to act on its behalf in accordance with board policies and standards to a committee of the board, an administrator, a carrier, a third party administrator, or to such other persons and entities as it deems necessary or reasonable for the effective and efficient administration of the Fund and the provisions of Chapter 87A of the Hawaii Revised Statutes; provided, however, that nothing in this rule shall permit the board to delegate its power to adopt, amend or repeal any rules.

1.10 State Ethics Code

All trustees and employees of the Fund shall comply with Chapter 84 of the Hawaii Revised Statutes.

1.11 Controlling Law

To the extent that federal or state law governs any matter covered by these rules, the Fund and the board shall comply with and follow such federal or state law. To the extent that any matter is not completely governed by federal or state law, the Fund and the board shall apply these rules to the extent reasonable and practicable.

1.12 Authority of the Board to Waive Rule Provisions

Subject to statutory requirements and limitations, the Board may waive an employee-beneficiary's compliance with any provision of the Fund's rules when the Board determines that: (a) good cause exists for such a waiver; and (b) such waiver does not involve any increase in the obligations or liabilities of the Fund beyond that which would have been involved if the employee-beneficiary had fully complied with the Fund's rules. Each waiver by the Board must be in writing and supported by documentation of the pertinent facts and grounds.

1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

(a) Employee-beneficiaries are responsible for:

(1) Providing current and accurate personal information as per Rules 4.06 and 4.07 within the times prescribed in these Rules;

(2) Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;

(3) Paying the employee's premium contributions at the times and in the manner designated by the board; and

(4) Complying with the Fund's rules.

(b) Any public employer whose current or former employees participate in Fund benefit plans is responsible for:

(1) Providing information, as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes, within the times prescribed by the Fund;

(2) Determining that employees are eligible to participate in Fund benefit plans pursuant to the definition of employee-beneficiary found in these rules and section 87A-1 of the Hawaii Revised Statutes;

(3) Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;

(4) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and

(5) Complying with the Fund's rules.

(c) The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

2.00 ADMINISTRATIVE PROCEDURES

2.01 Adoption, Amendment or Repeal of Rules

(a) The board may adopt, amend or repeal any rule of the Fund upon a motion of any trustee or upon the petition of an interested person or organization.

(b) In the case of an interested person or organization, the petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain:

(1) The petitioner's name, address, and telephone number;
(2) A statement of the nature of the petitioner's interest;
(3) A statement of the reasons for the proposed rule, amendment or repeal;
(4) A draft of the proposed rule, amendment or repeal; and
(5) The signature of the petitioner.

The board may reject any petition that does not contain the foregoing information.

(c) The board shall determine whether to deny or proceed with a petition within ninety (90) days. If the petition is denied, the board shall notify the interested person or organization in writing of the denial.

(d) If the board decides to proceed with any proposed rule change, whether by a trustee or interested person or organization, it shall consult with public employers and affected employee organizations with regard to the proposed rule change as follows. First, it shall transmit the proposed rule change to the public employers, exclusive employee organizations,

exclusive representatives, retiree organizations, and all other employee organizations registered with the board for consultation prior to adoption. Second, it shall provide the employers, representatives and organizations a reasonable amount of time for review and comment on the proposed change prior to final action by the board.

(e) After the consultation provided for in subsection (d), the proposed rule change shall be considered for adoption at an open meeting of the board that permits the attendance of interested persons.

(f) All proposed rule changes shall be adopted by the board in accordance with the provisions of section 87A-26 of the Hawaii Revised Statutes.

(g) New rules, amendments or repeals of rules that are adopted by the board shall be submitted to the governor for approval and filed with the lieutenant governor's office.

(h) Unless some other date is expressly selected by the board, a new rule, amendment of a rule, or repeal of a rule shall be effective the first day after the rule, amendment, or repeal is filed with the lieutenant governor's office.

2.02 Policies, Standards, and Procedures

Policies, standards and procedures to be adopted amended or repealed may, at the discretion of the board, be transmitted to public employers and affected employee organizations for consultation purposes. Nothing herein shall require the board to consult with public employers or affected employee organizations concerning the board's adoption, amendment or repeal of policies, standards and procedures or to transmit any such policies, standards or procedures to public employers or affected employee organizations for consultation purposes.

2.03 Declaratory Rulings

(a) Any interested person may petition the board for a declaratory ruling as to the applicability of any statutory provision administered by the board or of any rule or order of the Fund.

(b) Every petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain the following:

(1) The petitioner's name, address, and telephone number;
(2) A designation of the specific statute, rule or order in question;
(3) A statement of the nature of the petitioner's interest, including the reasons for the submittal of the petition;
(4) A complete statement of the relevant and material facts;
(5) A statement of the position or contentions of the petitioner; and
(6) A full discussion of the reasons, including any legal authorities, in support of the petitioner's position or contention.

The board may reject any petition that does not contain the foregoing information.

(c) Petitions to intervene and become a party to a declaratory ruling proceeding may be submitted in writing to the board. Such petitions shall contain the same information as required under subsection (b) and the grounds and reasons on which intervention is sought. The Board may deny intervention where the petition to intervene raises issues not reasonably pertinent to the issues already presented or the petition raises issues that would broaden the issues to be decided. If intervention is granted, the petitioner shall become a party to the proceeding to the degree permitted by the order granting intervention.

(d) The board may dismiss any petition for a declaratory ruling for good cause. Without limiting the generality of good cause, the board may dismiss a petition if:

(1) The question raised is purely speculative or hypothetical;
(2) The petitioner's interest is not of the type or nature that would give the petitioner standing to maintain an action if the petitioner were to seek judicial relief;
(3) The issuance of a declaratory ruling may adversely affect the interests of the employer, the board, any of the trustees, the Fund, or any of the Fund's officers or employees in litigation which is pending or reasonably expected to arise in the future; or
(4) The matter is not within the jurisdiction of the board.

(e) Subject to applicable federal and state law, the board at its discretion shall:

(1) Render a decision on the petition for a declaratory ruling without a hearing; or

(2) Hold a hearing and thereafter render its decision on the petition; or

(3) Refer the petition for consideration or hearing to the administrator, a special or standing committee of the board or any other person or entity duly designated by the board. After considering the recommendation of the administrator, committee or designated person or entity, the board shall render its decision on the petition.

Where any question of law is involved, the board may seek the assistance of the state attorney general in reviewing the matter. The board may also seek the assistance of other government agencies when necessary or desirable.

Any petitioner who desires a hearing shall submit a written request for a hearing together with the petition for a declaratory ruling. The written request shall set forth in detail the reasons why the matters alleged in the petition, together with supporting affidavits or other written evidence and briefs or memoranda of legal authorities, will not permit the fair and expeditious disposition of the petition and, to the extent that the request for a hearing is dependent upon factual assertions, shall submit affidavits or certificates establishing those facts.

(f) The petition for a declaratory ruling shall either be rejected in accordance with subsection (d) or acted upon by issuance of an order within ninety (90) days. Upon the disposition of the petition, the board shall promptly notify the petitioner.

(g) Orders disposing of petitions for a declaratory ruling will have the same status as other agency orders. An order shall be applicable only to the fact situation alleged in the petition or as set forth in the order. An order shall not be applicable to different fact situations or where additional facts exist that were not considered in the order.

2.04 Administrative Appeals (not related to Claim Filing and Appeals Information for Self-Insurance Plan Administered Benefits, which are discussed in Rule 2.06)

(a) A person aggrieved by one of the following eligibility decisions by the Fund may appeal to the board for relief from that decision:

(1) A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified-beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the Fund;
(2) A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
(3) A cancellation or termination of the person's enrollment in or coverage by a benefit plan, offered or sponsored by the Fund; or
(4) A refusal to reinstate the person's enrollment in or coverage by a benefit plan, offered or sponsored by the Fund.

(b) The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within one hundred eighty (180) days of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the one hundred eighty (180) day period has expired. The written appeal need not be in any particular form but should contain the following information:

(1) The aggrieved person's name, address, and telephone number;
(2) A description of the decision with respect to which relief is requested, including the date of the decision;
(3) A statement of the relevant and material facts; and
(4) A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

(c) If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within thirty (30) days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office within ninety (90) days of the administrator's action. If no action is taken by the administrator within thirty (30) days of the written appeal to the administrator being filed in the Fund's office, then the written appeal to the Board must be filed in duplicate in the Fund's office within one-hundred twenty (120) days of the written appeal to the administrator being filed in the Fund's office. The

written appeal need not be in any particular form but shall contain the following information:

(1) The aggrieved person's name, address and telephone number;
(2) A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
(3) A description of the decision with respect to which relief is requested, including, the date of the decision;
(4) A complete statement of the relevant and material facts;
(5) A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
(6) A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the board may reject any appeal that does not contain the foregoing information.

(d) The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

(e) The board shall grant or deny the appeal within forty-five (45) days of the date of the postmark of a request for appeal. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in these rules shall require the board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

(f) At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

2.05 Emergency Appeals of Eligibility

(a) The Board may appoint a sub-committee made up of two trustees, one from the employer group and one from the employee group, to hear and make final decisions on emergency appeals. The Board Chair shall appoint the sub-committee chair, which shall rotate between employer trustee and employee trustee every six months.

(b) An employee-beneficiary ("appellant") who is aggrieved by a plan administrator's decision denying or limiting eligibility for benefits provided under a plan offered by the Fund to the employee-beneficiary or a dependent-beneficiary enrolled by the employee beneficiary may make an emergency appeal directly to the Board where a delay in following the Fund's normal appeal process could in the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary:

(1) Seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary;
(2) Seriously jeopardize the employee-beneficiary's or dependent-beneficiary's ability to regain maximum functioning; or
(3) Subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

(c) Any appellant or designee desiring to make an emergency appeal under this Rule shall contact the Fund administrator and be prepared to provide the following information:

(1) The name, address, and telephone number of the appellant;
(2) A description of the decision with respect to which relief is requested; a statement as to why the appellant is appealing the decision, including all reasons that support the appellant's position or contentions; and any relevant and material facts;
(3) Why the appellant's appeal qualifies as an emergency appeal, i.e., why the appeal meets one or more of the conditions stated in subsection (b) above;
(4) Information that supports the appellant's appeal, including, but not limited to, any opinions from physicians that show that the appeal should be handled as an emergency appeal; and

(5) If appellant is going to be represented by a designee, proof the designee may act on behalf of the appellant.

Notwithstanding the foregoing, the Fund administrator may waive the foregoing requirements if the Fund administrator finds that the criteria for making an emergency appeal are present and circumstances prevent the appellant from providing information or documents required in 1 through 5 above.

(d) The Fund administrator shall expeditiously, but in no event later than two business days, determine whether the request for emergency appeal qualifies as an emergency appeal under the criteria stated in this Rule. If the Fund administrator determines that the request for emergency appeal does not qualify as an emergency appeal, the appellant's appeal shall be handled as a normal appeal. Appellant may appeal the Fund administrator's denial of a request for emergency appeal by submitting a request to the Fund Administrator. No particular form is required for such a request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.

(e) Upon determining that an appeal qualifies as an emergency appeal or upon receipt of an appeal of the Fund administrator's denial of a request for emergency appeal, the Fund administrator shall take the following actions:

(1) Set a time and date of a hearing when the sub-committee can meet either in person or via phone. The hearing shall be set as soon as possible.
(2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;
(3) The Fund administrator may request the parties to provide the Fund administrator with copies of any documents, records, written testimony, or other written evidence that they wish the sub-committee to consider at the hearing; and
(4) Prior to the hearing, the Fund administrator shall provide each member of the sub-committee with copies of any materials provided by the appellant.

(f) Unless the appellant expressly requests a public hearing, any hearing under this Rule shall be closed to the public. At the hearing, the following procedures shall apply:

(1) The sub-committee shall hear and consider all relevant testimony and documents;
(2) At any time during the hearing, the sub-committee may enter executive session to consult counsel regarding any legal issues involved in the appeal; and
(3) Prior to the conclusion of the hearing, the sub-committee shall announce its decision on the appeal to the Fund administrator. The sub-committee shall subsequently issue its decision in writing. A certified copy of the written decision shall be sent by certified mail to the appellant within a reasonable time after the hearing.

(g) The Fund administrator may designate one or more EUTF staff members to perform any or all of the Fund administrator's duties under this Rule when the Fund administrator is unavailable or otherwise unable to perform such duties.

2.06 Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits

(a) This section describes the self-insured plans appeals timing and processes if an employee-beneficiary or dependent-beneficiary receives an adverse benefit determination. The process will be in conformance with 29CFR 2560.503 and amendments thereto. The processes are comprised of the following:

(1) Internal standard appeal;
(2) External Appeal using the Independent Review Organization (IRO);
(3) Internal expedited appeal for urgent care;
(4) External appeal using an IRO for urgent care.

(b) Definitions pertinent to claims and appeals.
(1) "Adverse benefit determination", a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Fund benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Fund benefit based on the application of a utilization review. An adverse benefit determination also includes a failure to cover a Fund benefit

because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.

(2) "Fund Benefit", when referenced in this Section 2.06, a Fund benefit refers specifically to a self insured plan administered benefit.

(3) "Claim", a request for a Fund benefit that is made in accordance with the Fund's established procedures for filing benefit claims.

(4) "Medically Necessary" (Medical Necessity), medications, health care services or products are considered medically necessary if:

i. Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;

ii. Use of the medication, service, or product is based on recognized standards for the health care specialty involved;

iii. Use of the medication, service, or product represents the most appropriate level of care for the individual, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and

iv. Use of medication, service or product is not solely for the convenience of the individual, individual's family, or provider.

(5) "Post-Service Claim", a claim for a Fund benefit that is not a Pre-Service Claim.

(6) "Pre-Authorization", pre-service review of an employee-beneficiary's or dependent-beneficiary's initial request for a particular medication, service or product. The self-insured plan administrator will apply a set of pre-defined criteria to determine whether there is need for the requested medication, service, or product.

(7) "Pre-Service Claim", a claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-service claims include individual requests for pre-authorization.

(8) "Urgent Care Claim", a claim for a medication, service, or product where a delay in processing the claim: (a) could seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-

beneficiary's failure to regain maximum function, or (b) in the opinion of a physician with knowledge of the employee-beneficiary's condition, would subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the requested medication, service, or product.

(c) Time limit for initial filing of self-insured plan and administered claims.

(1) All post-service self-insured plan administered claims must be submitted to the administrator within one year from the date of service. No plan benefit will be paid for any claim not submitted within this period.

(2) If a self-insured plan claim is not approved, an employee-beneficiary or dependent-beneficiary may appeal that denial by following the steps in this Claim Filing and Appeal section. The Fund has delegated final claims and appeal authority for self-insured plan administered benefits to the independent self-insured plan administrator. This section discusses the claim appeal process for the following types of claims: Pre-Authorization Claim Review Services, Pre-Service Appeals Review Services, and Post-Service Appeals Review Services.

(d) The claims and appeals process

(1) Pre-authorization review. The self-insured plan administrator will implement the cost containment programs by comparing individual requests for certain medicines, services, or products and/or other benefits against pre-defined lists or formularies before those prescriptions, services, or products are approved. If the self-insured plan administrator determines that the employee-beneficiary or dependent-beneficiary's request for pre-authorization cannot be approved, that determination will constitute an adverse benefit determination.

(2) Appeals of adverse benefit determinations of pre-service and urgent care claims. If an adverse benefit determination is rendered on the employee-beneficiary or dependent-beneficiary's self-insured plan administered claim, the employee-beneficiary or dependent-beneficiary may file an appeal of that determination. The individual's appeal of the adverse benefit determination must be made in writing and submitted to the self-insured plan administrator within one hundred eighty (180) days after the

employee-beneficiary or dependent-beneficiary receives notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, the employee-beneficiary or dependent-beneficiary and/or the employee-beneficiary or dependent-beneficiary's attending physician may submit an appeal by contacting the self-insured plan administrator. The employee-beneficiary or dependent-beneficiary's appeal should include the following information:

(i) Name of the person the appeal is being filed for;
(ii) The prescription drug program identification number, service description and/or code, or product name and number;
(iii) Date of birth;
(iv) Written statement of the issue(s) being appealed;
(v) Prescription drug name(s), service(s), or product(s) being requested; and
(vi) Written comments, documents, records or other information relating to the claim.

The employee-beneficiary or dependent-beneficiary's appeal and supporting documentation should be mailed, emailed, or faxed to the self-insured plan administrator.

If a covered person or their covered dependent does not understand English and has questions about a claim denial, the covered person or covered dependent should contact the appropriate claims administrator to find out if assistance is available.

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa ang EUTF.
CHINESE (中文): **如果需要中文的帮助**，请拨 EUTF.

(3) The self-insured plan administered program's review. The self-insured plan administrator will provide the first-level review of appeals of pre-service claims. If the employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's

decision, the employee-beneficiary or dependent-beneficiary can request an additional second-level medical necessity review. That review will be conducted by an Independent Review Organization ("IRO").

(4) Timing of review.

(i) Pre-Authorization Review. The self-insured plan administrator will make a decision on a pre-authorization request for a Fund benefit within fifteen (15) days after it receives the request. If the request relates to an urgent care claim, the self-insured plan administrator will make a decision on the claim within seventy-two (72) hours.

(ii) Pre-Service Claim Appeal. The self-insured plan administrator will make a decision on a first-level appeal of an adverse benefit determination rendered on a pre-service claim within fifteen (15) days after it receives the employee-beneficiary or dependent-beneficiary's appeal. If the self-insured plan administrator renders an adverse benefit determination on the first-level appeal of the pre-service claim, the employee-beneficiary or dependent-beneficiary may appeal that decision by providing the information described above. A decision on the employee-beneficiary or dependent-beneficiary's second-level appeal of the adverse benefit determination will be made (by the IRO) within fifteen (15) days after the new appeal is received. If the employee-beneficiary or dependent-beneficiary is appealing an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than seventy-two (72) hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

(iii) Post-Service Claim Appeal. The self-insured plan administrator will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim within sixty (60) days after it receives the appeal.

(5) Scope of review. During its pre-authorization review, first-level review of the appeal of a pre-service claim, or review of a post-service claim, the self-insured plan administrator will:

(i) Take into account all comments, documents, records and other information submitted by the employee-beneficiary or dependent-beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim;

(ii) Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Fund documents;

(iii) Follow reasonable procedures to ensure that the applicable Fund provisions are applied to the employee-beneficiary or dependent-beneficiary in a manner consistent with how such provisions have been applied to other similarly-situated individuals; and

(iv) Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If an employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's denial of a pre-service claim, and requests an additional second-level medical necessity review by an IRO, the IRO shall:

a) Consult with appropriate health care professionals who were not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual);

b) Identify the health care professional, if any, whose advice was obtained on behalf of the Fund in connection with the adverse benefit determination; and

c) Provide for an expedited review process for urgent care claims.

(6) Notice of adverse benefit determination. Following the review of an employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary of any adverse benefit determination in writing. (Decisions on urgent care claims will be also communicated by telephone or fax.) This notice will include:

(i) The specific reason or reasons for the adverse benefit determination;

(ii) Reference to the pertinent Fund provision on which the adverse benefit determination was based;

(iii) A statement that the employee-beneficiary or dependent-beneficiary is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

(iv) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and

(v) If the adverse benefit determination is based on a medical necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Fund to the employee-beneficiary or dependent-beneficiary's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

(7) Authority as claims fiduciary. The self-insured plan administrator has been designated by the Board as the claims fiduciary with respect to all types of claim appeal review of the benefit claims arising under the Fund it administers. The self-insured plan administrator shall have, on behalf of the Fund, sole and complete discretionary authority to determine these claims conclusively for all parties. The self-insured plan administrator is not responsible for the conduct of any second-level medical necessity review performed by an IRO.

(8) Voluntary external review. The Patient Protection and Affordable Care Act ("ACA") imposes external review requirements on group health plans, including outpatient prescription drug benefits. Under the ACA, an employee-beneficiary or dependent-beneficiary who receives a final internal adverse determination of a "Claim" for benefits under a self-insured administered plan may be permitted to further appeal that denial using the voluntary external

review process. The external review process provides employee-beneficiary or dependent-beneficiary's with another option for protesting the denial of their claim.

(9) Standard/non-expedited Federal external review process.

(i) Request for review. An employee-beneficiary or dependent-beneficiary whose claim for self-insured administered benefits is denied may request, in writing, an external review of his or her claim within four (4) months after receiving notice of the final internal adverse benefit determination. The employee-beneficiary or dependent-beneficiary's request should include their name, contact information including mailing address and daytime phone number, individual ID number, and a copy of the coverage denial. The employee-beneficiary or dependent-beneficiary's request for external review and supporting documentation may be mailed, emailed, or faxed to the self-insured plan administrator at their address, email, or fax.

(ii) Preliminary review. Within five (5) days of receiving an employee-beneficiary or dependent-beneficiary's request for external review, the self-insured plan administrator will conduct a "preliminary review" to ensure that the request qualifies for external review. In this preliminary review, the self-insured plan administrator will determine whether:

a) The employee-beneficiary or dependent-beneficiary is or was covered under the Fund at the time the benefit at issue was requested, or in the case of a retrospective review, was covered at the time the benefit was provided;

b) The adverse benefit determination or final internal adverse benefit determination does not relate to the employee-beneficiary or dependent-beneficiary's failure to meet the Fund's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal external review;

c) The employee-beneficiary or dependent-beneficiary has exhausted the Fund's internal appeal process

(unless the employee-beneficiary or dependent-beneficiary's Claim is "deemed exhausted" under the ACA); and

d) The employee-beneficiary or dependent-beneficiary has provided all the information and forms necessary to process the external review.

Within one (1) day after completing this preliminary review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary, in writing, that: (1) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (2) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (3) the request for external review is complete, but not eligible for review.

(iii) Referral to IRO. If the employee-beneficiary or dependent-beneficiary's request for external review is complete and the employee-beneficiary or dependent-beneficiary's claim is eligible for external review, the self-insured plan administrator will assign the request to one of the IROs with which the administrator has contracted. The IRO will notify the employee-beneficiary or dependent-beneficiary of its acceptance of the assignment. The employee-beneficiary or dependent-beneficiary will then have ten (10) days to provide the IRO with any additional information the employee-beneficiary or dependent-beneficiary wants the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Fund.

The IRO may consider information beyond the records for the employee-beneficiary or dependent-beneficiary's denied Claim, such as:

a) The employee-beneficiary or dependent-beneficiary's medical records;

b) The attending health care professional's recommendations;

c) Reports from appropriate health care professionals and other documents submitted by the Fund, the employee-beneficiary or dependent-beneficiary, or the employee-beneficiary or dependent-beneficiary's treating physician;

d) The terms of the Fund to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);

e) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;

f) Any applicable clinical review criteria developed and used on behalf of the Fund (unless the criteria are inconsistent with the terms of the Fund or applicable law); and

g) The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the employee-beneficiary or dependent-beneficiary's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

(iv) Timing of IRO's determination. The IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator (on behalf of the Fund) with written notice of its final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO's notice will contain:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if available), the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials);

b) The date the IRO received the external review assignment from the self-insured plan administrator, and the date of the IRO's decision;

c) References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;

e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to the either the Fund or to the individual;

f) A statement that the employee-beneficiary or dependent-beneficiary may still be eligible to seek judicial review of any adverse external review determination; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the employee-beneficiary or dependent-beneficiary.

(10) Reversal of the Fund's prior decision. If the self-insured plan administrator, acting on the Fund's behalf, receives notice from the IRO that it has reversed the prior determination of the employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will immediately provide coverage or payment for the claim.

(11) Expedited Federal external review process. An employee-beneficiary or dependent-beneficiary may request an expedited external review:

(i) If the employee-beneficiary or dependent-beneficiary receives an adverse benefit determination related to a claim that involves a medical condition for which the timeframe for completion of a an expedited internal appeal would seriously jeopardize the life or health of the employee-

beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function, and the employee-beneficiary or dependent-beneficiary has filed a request for an expedited internal appeal; or

(ii) If the employee-beneficiary or dependent-beneficiary receives a final internal adverse benefit determination related to a claim that involves: (a) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function; or (b) an admission, availability of care, continued stay, or a prescription drug benefit for which the employee-beneficiary or dependent-beneficiary has received emergency services, but has not been discharged from a facility.

(12) Request for review. If the employee-beneficiary or dependent-beneficiary's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the employee-beneficiary or dependent-beneficiary or the employee-beneficiary or dependent-beneficiary's physician may request an expedited external review by calling the customer care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include the employee-beneficiary or dependent-beneficiary's name, contact information including mailing address and daytime phone number, employee-beneficiary or dependent-beneficiary's ID number, and a description of the coverage denial. Alternatively, a request for expedited external review may be faxed; employee-beneficiary or dependent-beneficiary contact information and coverage denial description, and supporting documentation may be faxed or emailed to the attention the self-insured plan administrator's external review appeals department. All requests for expedited review must be clearly identified as "urgent" at submission.

(13) Preliminary review. Immediately on receipt of an employee-beneficiary or dependent-beneficiary's request for expedited

external review, the self-insured plan administrator will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary that: (i) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

(14) Referral to IRO. Upon determining that an employee-beneficiary or dependent-beneficiary's request is eligible for expedited external review, the self-insured plan administrator will assign an IRO to review the employee-beneficiary or dependent-beneficiary's claim. The self-insured plan administrator will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the employee-beneficiary or dependent-beneficiary's claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Fund during the internal claims and appeals process.

(15) Timing of the IRO's determination. The IRO must provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator, on behalf of the Fund, with notice of its determination as expeditiously as the employee-beneficiary or dependent-beneficiary's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the employee-beneficiary or dependent-beneficiary's request for external review. If this notice is not provided in writing from the IRO and is provided orally, within forty-eight (48) hours after providing the oral notice, the IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan

administrator, on behalf of the Fund, with written confirmation of its decision.

(16) Authority for review. The self-insured plan administrator will be responsible only for conducting the preliminary review of an employee-beneficiary or dependent-beneficiary's request for external review, ensuring that the individual is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO. The actual external review of an employee-beneficiary or dependent-beneficiary's appeal will be conducted by the assigned independent review organization (IRO). The self-insured plan administrator is not responsible for the conduct of the external review performed by an IRO.

(e) Facility of payment. If the Fund administrator or its designee determines that an employee-beneficiary or dependent-beneficiary cannot submit a claim or prove that an employee-beneficiary or dependent-beneficiary paid any or all of the charges for health care services that are covered by the Fund because an employee-beneficiary or dependent-beneficiary is incompetent, incapacitated or in a coma, the Fund may, at its discretion, pay Fund benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for an employee-beneficiary or dependent-beneficiary care and support. Any such payment of Fund benefits will completely discharge the Fund's obligations to the extent of that payment. Neither the Fund, administrator, claim administrator nor any other designee of the Fund administrator will be required to see to the application of the money so paid.

(f) Discretionary authority of Fund administrator and designees. In carrying out their respective responsibilities under the Fund, the Fund administrator or its designee, other plan fiduciaries, and the self-insured plan administrator, have full discretionary authority to interpret the terms of the plan and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(g) Elimination of conflict of interest. To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

(h) Limitation on when a lawsuit may be started. An employee-beneficiary or dependent-beneficiary or any other claimant may not start a lawsuit to obtain Fund benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Fund's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until ninety (90) days have elapsed since an employee-beneficiary or dependent-beneficiary filed a request for appeal review if an employee-beneficiary or dependent-beneficiary have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services were provided.

3.00 ELIGIBLITY FOR ENROLLMENT

3.01 Health Benefits

(a) Employee-beneficiaries. The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the Fund:

(1) An employee;
(2) A retired employee;
(3) The surviving spouse or partner of an employee who is killed in the performance of the employee's duty or of a deceased retired employee, provided the surviving spouse or partner does not remarry or enter into another partnership;
(4) The unmarried child of an employee who is killed in the performance of the employee's duty, provided the child is under the limiting age, as defined in Rule 1.02 or is an adult disabled child in accordance with Rule 3.01(b)(3) and does not have a surviving parent who is eligible to be an employee-beneficiary; and
(5) The unmarried child of a deceased retired employee, provided the child is under the limiting age, as defined in Rule 1.02, and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsection (3) above, a surviving spouse or partner ceases to be an eligible employee-beneficiary once the spouse or partner remarries or enters into another partnership even though the spouse or partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of a civil union or death. A surviving partner shall not cease to be eligible under subsection (3) because the death of the employee or retired employee prevents him or her from further meeting the requirements of parts (1), (2), (3), (6), and (8) of the definition of "domestic or civil union partner" in Rule 1.02. With respect to subsection (4) and (5), an unmarried child

ceases to be eligible as of midnight of the birthday in which the child reaches the limiting age, as defined in Rule 1.02.

Notwithstanding any other provision in these rules to the contrary, a retired employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for medical or prescription drug coverage offered or sponsored by the Fund until the employee-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

An employee-beneficiary who is in Cancellation Non-Payment Status is not eligible for enrollment in Fund health benefit plans until the plan year following the cancellation. The employee-beneficiary may enroll during the Fund's open enrollment period or upon experiencing a mid-year qualifying event in a plan year following the cancellation.

(b) Dependent-beneficiaries of active employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for active employees:

(1) An employee-beneficiary's spouse or partner;
(2) An employee-beneficiary's, spouse's or partner's child, provided the child is under the limiting age, as defined in Rule 1.02 for excepted and non-excepted benefits;
(3) An employee-beneficiary's, spouse's or partner's unmarried child regardless of age, who is incapable of self-support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
(4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday

for excepted benefits as defined in Rule 1.02, as applicable. For non-excepted benefits, coverages are terminated at the end of the month in which the child turns twenty-six. With respect to subsections (2) and (3), the child of a spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four for excepted benefits as defined in Rule 1.02, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

(c) Dependent-beneficiaries of retired employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for retired employees:

(1) An employee-beneficiary's spouse or partner;
(2) An employee-beneficiary's, spouse's or partner's unmarried child, provided the child is under the limiting age, as defined in Rule 1.02;
(3) An employee-beneficiary's, spouse's or partner's unmarried child, regardless of age, who is incapable of self support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
(4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday, as applicable. With respect to subsections (2) and (3), the child of a spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four, the employee-beneficiary shall provide the Fund with written

proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

Notwithstanding any other provisions in these rules to the contrary, a dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for medical or prescription drug coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

3.02 HSTA VB Health Benefits Offered by the Fund

(a) Eligibility. Employee-beneficiaries who were enrolled in the HSTA VB health benefit plan(s) effective January 1, 2011 upon the dissolution of the HSTA Voluntary Employees Beneficiary Association Trust and their dependent-beneficiaries who meet the eligibility requirements detailed in Rule 3.01.

(b) An employee-beneficiary who voluntarily enrolls in a non-HSTA VB plan offered by the Fund shall permanently forfeit their eligibility in the HSTA VB health benefit plans. This shall include a bargaining unit change even if the employee-beneficiary subsequently returns to bargaining unit 05. This shall not apply to an employee-beneficiary who enrolls as a dependent-beneficiary in a non-HSTA VB plan offered by the Fund provided the employee-beneficiary remains enrolled in the HSTA VB life insurance.

3.03 Group Life Insurance

Employees and retired employees are eligible to enroll for any group life insurance plans offered or sponsored by the Fund.

4.00 ENROLLMENT PROCEDURES

4.01 Application for Enrollment

(a) An employee-beneficiary shall file an enrollment application, in the form prescribed by the board or by the board's policy, to enroll, change or cancel an enrollment in any benefit plan offered or sponsored by the Fund. Unless otherwise provided by the board or by the board's policy, all enrollment applications shall be filed by the employee-beneficiary with: (1) in the case of an employee, the employee's employer; and (2) in all other cases, the Fund. Notwithstanding the foregoing, upon retirement and thereafter, an employee-beneficiary shall file an enrollment application to enroll or change enrollment in the benefit plans offered or sponsored by the Fund with the Fund.

(b) Where an employee-beneficiary files more than one enrollment application, the enrollment application bearing the latest filing date shall be the one used by the Fund to process the employee-beneficiary's enrollment, provided the employee-beneficiary is eligible for such enrollment.

(c) With due consideration of appropriate federal or state laws, the board shall set the standards and procedures for filing such enrollment applications, including, but not limited to, the form of such enrollment applications, the information required to be provided by the employee-beneficiary on such enrollment applications, and the method for filing such enrollment applications. Enrollment applications shall include the employee-beneficiary's authorization to the state comptroller or the appropriate county director of finance to assign sufficient compensation to the Fund in payment of all contributions due from such employee-beneficiary for enrollment or coverage in any and all Fund benefit plans.

(d) A representative of an employee-beneficiary may file an enrollment application for the employee-beneficiary if:

(1) The representative has a written authorization signed by the employee-beneficiary that authorizes the representative to file such enrollment applications as provided by State and Federal law; or

(2) A valid court order authorizes the representative to file such enrollment applications.

4.02 Rejection of an Enrollment Application

(a) Any enrollment application may be partially or fully rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

(b) An enrollment application shall be rejected if:

(1) The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
(2) The application is not filed within the time limitations prescribed by these rules;
(3) The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
(4) The employee-beneficiary is ineligible due to outstanding past due contributions or other amounts to the Fund, or is ineligible due to Cancellation Non-Payment Status; or
(5) Acceptance of the application would violate applicable federal or state law or any other provision of these rules.

(c) Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

4.03 Dual or Multiple Enrollment

No person may be enrolled simultaneously in any benefit plan offered or sponsored by the Fund as both an employee-beneficiary and a dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.

4.04 Date of Filing

An employee-beneficiary's enrollment application, beneficiary designation, or any other form required to be filed with the Fund shall be deemed to have been filed with the Fund on the date that the following entities, as applicable, actually receive such forms: (1) the employee's employer; (2) in the case of a retired employee, surviving spouse or partner under Rule 3.01, and unmarried child under Rule 3.01, the Fund; (3) or others, as specified by the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, or other form shall be deemed to have been filed on the date that the person would have been first eligible to file that document.

4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates

Except as otherwise provided in these rules or by applicable federal or state law, the following shall apply to all applications to enroll in the benefit plans offered or sponsored by the Fund, to add or delete dependent-beneficiaries, or to change enrollments or coverages:

(a) No enrollment of an employee-beneficiary, addition or deletion of a dependent-beneficiary, or change in an enrollment or coverage shall be effective without the filing of a properly completed enrollment application and any required proof documents within forty five (45) days of the specified event that allows the filing of the application except for the following events: (1) termination of employment for which the enrollment application must be filed within thirty (30) days of the termination of employment; (2) newborns for which the enrollment application and required proof documents must be filed within one hundred eighty (180) days of the birth; (3) retirement, and surviving spouse, partner or child who become eligible as an employee-beneficiary under Rule 3.01 for

which an enrollment application and required proof documents must be filed within sixty (60) days of the event.

(b) An employee-beneficiary who fails to file an enrollment application and required proof documents within the time prescribed by subsection (a) above or any otherwise applicable rule shall result in the rejection of the requested enrollment changes and not be permitted to file that application until the next regular open or additional limited enrollment period.

(c) An application will not be processed if it does not include a Social Security (SSN) for an employee-beneficiary and/or a SSN or Individual Taxpayer Identification Number (ITIN) for a dependent-beneficiary for whom enrollment is being requested. The employee-beneficiary and/or dependent-beneficiary shall be added retroactive to the effective date of the event upon the Fund's receipt of the employee-beneficiary and/or dependent-beneficiary's SSN or ITIN.

4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund in writing of any changes in the employee-beneficiary's name or address or marital or partnership status, the birth or adoption of a child or any other changes in the family status of the employee-beneficiary, and any other material changes in the information previously filed by the employee-beneficiary as part of an enrollment application. Each notice to the Fund shall be submitted through the employee-beneficiary's employer or, if none, shall be submitted directly to the Fund.

4.07 Verification of Eligibility

The board may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in Fund benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the employee-beneficiary or dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.11(c).

4.08 Regular Open and Additional Limited Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during a regular open or additional limited enrollment period to make any one or a combination of enrollment changes that

have been approved by the board for that regular open or additional limited enrollment period. The changes that the board may approve include, but are not limited to, changes from non-enrolled to enrolled status, changes between plans, changes in levels of coverage, and cancellations. All changes made shall become effective on the date approved by the board for the regular open or additional limited enrollment period.

4.09 Continuation of Coverage

Subject to applicable federal and state law, coverage under the benefit plans offered or sponsored by the Fund shall continue:

(a) Provided the employee-beneficiary meets the eligibility provisions of Rule 3.01 and pays the employee-beneficiary's premium contribution as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement;

(b) While the employee-beneficiary participates in an employee strike authorized by chapter 89, Hawaii Revised Statutes, provided that nothing in this rule shall limit the right or ability of the Fund to collect premium contributions from any public employer or employee-beneficiaries or the remedies available to the Fund to collect such premium contributions.

(c) When an employee terminates employment and is rehired by the same public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment, such as when the employee terminates employment with the state and is rehired with the state, or when the employee terminates employment with a county and is rehired by the same county. The employee shall be treated as if continuously enrolled in the Fund benefit plans in which the employee was enrolled at the time of termination and shall be required to pay the full cost of coverage to the extent that such is not paid by the employee's public employer. When an employee terminates employment and is rehired by a different public employer within the same pay period or the next consecutive pay period, such as when the employee terminates employment with the state and is hired by a county or terminates one county and is rehired by a different county, the employee shall be allowed to change between plans, including adding or dropping dependents and changing tiers. Notwithstanding the definitions of "employer" and "public employer" set forth and used in these rules, for purposes of this section only, the different public employers are: 1) State,

including executive, legislative, and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all Charter Schools; 2) City and County of Honolulu; 3) County of Hawaii; 4) County of Maui, and 5) County of Kauai. Changes shall become effective at the beginning of the next pay period in which the termination of employment occurred, without a break in coverage.

4.10 Contribution Shortage

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly or monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within thirty (30) days of the date on which the required semi-monthly or monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.11(b), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.13(b).

4.10.5 Contribution Refund

The Fund may refund employee-beneficiaries or dependent-beneficiaries any amounts deemed owing, provided that at the time of the disbursement of such refunds, no refund need be made where the amount thereof is less than one dollar.

4.10.7 Overdraft or Non-Sufficient Funds Fees

Employee-Beneficiaries may be required to reimburse the Fund for any amounts relating to overdraft or non-sufficient funds fees.

4.11 Cancellation of Enrollment; Effective Dates of Cancellation

(a) Cancellation Due to Ineligibility. The enrollment of any ineligible person who was enrolled in error or is ineligible to enroll in or be covered in a benefit plan offered or sponsored by the Fund shall be canceled:

(1) When the person is notified by the Fund of the error or ineligibility prior to the effective date of the enrollment, the person shall be treated as if the enrollment application was not submitted.

(2) When the person is notified by the Fund in writing after the effective date of the enrollment, but at least thirty (30) days in advance, the enrollment may be canceled retroactively (a rescission) to the date the person was ineligible if cancellation is due to Fraud or Intentional Misrepresentation of a material fact, as defined in Rule 1.02 or

(3) When the person is notified by the Fund in writing after the effective date of the enrollment, the enrollment will be cancelled prospectively effective the first day of the first pay period following the date that ineligibility is determined by the Fund. Employee-beneficiaries may be liable for the employer portion of premiums paid for any ineligible person and/or any benefits that were provided as per Rule 4.12(d).

(b) Cancellation Due to Failure to Pay Contribution Shortage. If an employee-beneficiary does not make full payment of all contributions due within thirty (30) days of the date of the notice of contribution shortage in Rule 4.10, the employee-beneficiary's enrollment in all health benefit plans, and all dependent-beneficiaries' health benefit plans under that enrollment shall be cancelled as of the first day following the last period for which full payment of the employee-beneficiary's required semi-monthly or monthly contributions were paid and transmitted to the Fund and the employee-beneficiary will be ineligible for fund health benefits. If an employee-beneficiary is currently on a leave of absence covered under the Family Medical Leave Act (FMLA), the employee-beneficiary and dependent beneficiary(s) enrollment in all health benefit plans shall be cancelled thirty (30) days from the date of the notice of contribution shortage. The employee-beneficiary may only apply for a new enrollment as per Rule 4.13(a). However, the enrollment and eligibility for benefits of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.13(b). Cancellation of an employee-beneficiary's enrollment pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.

(c) Cancellation Due to Failure to Comply with Rules. If an employee-beneficiary materially fails to comply with any of the Fund's rules, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be canceled after thirty (30) days advance

written notice of such has been provided to the employee-beneficiary. The board may set standards and procedures for providing notice to employee-beneficiaries under this rule. The notice shall at a minimum specify how the employee-beneficiary has failed to comply with the Fund's rules, and a date by which the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation. The effective date of the cancellation shall be the date set forth in the notice as to when the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation.

(d) Cancellation Due to Acquiring Coverage From a Non-Fund Plan. An employee-beneficiary or dependent-beneficiary may cancel enrollment in a Fund benefit plan upon acquiring coverage from a non-Fund plan or when moving to a country in which they are eligible for publicly provided healthcare or similar, by filing an enrollment application to the employee-beneficiary's employer or, if none, directly with the Fund requesting cancellation. The enrollment application must be filed with the employee-beneficiary's employer, or, if none, directly to the Fund within forty five (45) days of acquiring coverage from the non-Fund plan, sixty (60) days when the non-Fund plan is a Medicaid plan, or moving to another country as noted above. The effective date of cancellation shall be the end of the pay period in which the employee-beneficiary or dependent-beneficiary moves to another country as noted above or acquires coverage from the non-Fund plan, except when the employee-beneficiary or dependent-beneficiary acquires coverage from the non-Fund plan on the first or the sixteenth of the month, in which case coverage ends at the end of the prior pay period.

The Fund shall determine the required proof documents.

(e) Cancellation When Beginning a Leave of Absence Without Pay. An employee-beneficiary may voluntarily cancel enrollment in all Fund benefit plans when beginning a leave of absence without pay that is expected to last more than one month. An enrollment application must be filed with the employee-beneficiary's employer requesting cancellation of all plans within forty five (45) days of the beginning of the leave of absence without pay. The effective date of the cancellation shall be the end of the pay period during which the leave of absence without pay begins. Employee-beneficiaries who cancel coverage in accordance with this section may re-enroll in the same benefit plans upon return from the leave of absence without pay by completing an enrollment application and

submitting it to the employee-beneficiary's employer within forty five (45) days of returning from the leave of absence.

4.12 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Change in Employment Status. An employee-beneficiary's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the employee-beneficiary's loss of eligibility to participate in such plans due to a change in employment status. The effective date of the termination shall be the first day of the pay period following the effective date of the change in employment status, provided the termination is not retroactive. If, by virtue of an administrative error, coverage continues to be provided by the Fund, and paid for by the employee-beneficiary, the effective date of cancellation shall be the last day of the pay period following the date of issuance of a thirty (30) days written notice. Employers shall submit to the Fund the enrollment application within thirty (30) days of the change in employment status causing termination of enrollment. Employers submitting enrollment applications after thirty (30) days of the change in employment status may be responsible for 100% of the premiums, both employer and employee contributions, until such termination.

(b) Termination Due to Filing of Fraudulent Claims. An employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be terminated upon thirty (30) days advance written notice if the employee-beneficiary files fraudulent claims for benefit. A dependent-beneficiary's coverage in all of the benefit plans offered or sponsored by the Fund may be terminated if the dependent-beneficiary files fraudulent claims for coverage and/or benefits. The effective date of the termination shall be the date that the Fund determines that the employee-beneficiary or dependent-beneficiary, as applicable, has filed fraudulent claims.

(c) Notice to the Fund. If an event occurs that makes a person ineligible for continued enrollment or coverage in the benefit plans offered or sponsored by the Fund, that person or employee-beneficiary shall notify the Fund of the event within forty five (45) days. All such notices shall be in writing and shall be sent to the Fund.

(d) Recovery of Benefits. In all situations in which an ineligible person receives benefits under the Fund, or the employee-beneficiary or dependent-beneficiary files fraudulent claims for benefits per Rule 4.12(b), the Fund shall be entitled to seek recovery of any benefits that were provided to any person or seek recovery of the employer contributions paid for any ineligible person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment in or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule and in situations in which the Fund overpays amounts to an employee-beneficiary or dependent-beneficiary, the Fund shall have the rights of offset and set-off, including without limitation, the right to recover amounts from and out of any and all future payments to the person whose enrollment was terminated, who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans or who was overpaid.

4.13 Reinstatement of Enrollment

(a) General Rule. Unless another rule of the Fund expressly applies, an employee-beneficiary whose enrollment in any of the Fund's benefit plans has been cancelled or terminated may not apply for reinstatement in those benefit plans. The employee-beneficiary may only apply for a new enrollment during the Fund's open enrollment period or upon experiencing a mid-year qualifying event in any plan year following the cancellation. Any such new enrollment may be conditioned upon the employee-beneficiary meeting all the Fund's rules for eligibility and enrollment, curing any past deficiencies or failures that led to the employee-beneficiary's cancellation or termination, and providing adequate assurance that the employee-beneficiary will not further engage in the conduct that previously led to the employee-beneficiary's cancellation or termination. Nothing in this rule shall be deemed to require the Fund to re-enroll any employee-beneficiary whose enrollment has been previously cancelled or terminated.

(b) Contribution Shortage Cancellation. If an employee-beneficiary's enrollment in the Fund's benefit plan or plans has been cancelled under Rule 4.11(b), the employee-beneficiary's enrollment in such benefit plan or plans may be reinstated if the employee-beneficiary makes full payment of all contributions due from the employee-beneficiary within sixty (60) days from the date of the notice of cancellation in accordance with

cancellation of enrollment under Rule 4.11(b) and whose enrollment has not been cancelled under Rule 4.11(b) within twelve (12) months of the date of the notice of cancellation. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. Employee-beneficiaries who are currently on leave of absence covered under the FMLA or Uniform Services Employment and Reemployment Rights Act (USERRA) shall be allowed to re-enroll in coverage as per Rule 5.06(c).

(c) Reinstatement Upon Return From Lawful Strike. If an employee-beneficiary's enrollment is cancelled for non-payment during a lawful strike, the employee-beneficiary may re-enroll upon return from the lawful strike without the requirement to pay back premiums and without coverage during the non-payment period under the following conditions:

(1) The employee-beneficiary files an enrollment application within forty five (45) days of returning from the lawful strike, and
(2) The employee-beneficiary and any covered dependent-beneficiaries had no covered services during the non-payment period.
(3) The employee-beneficiary enrolls in the same plans and at the same tier the employee-beneficiary was enrolled in prior to the lawful strike.

The effective date of coverage shall be the date the employee-beneficiary returns from the lawful strike.

4.14 Mandatory Enrollment in Recurring Electronic Premium Deductions

(a) Employee-beneficiaries who retire or become a surviving-beneficiary on or after September 15, 2020 and who are required to pay all or a portion of their premiums shall have their share of premiums electronically deducted and transmitted to the Fund monthly by the Employees' Retirement System of the State of Hawaii or the employee-beneficiary's financial institution. Premium payments shall be made electronically unless waived by the Fund and another method is determined to be more appropriate.

(b) New Enrollment in Recurring Electronic Premium Deductions. Employee-beneficiaries who are required to pay a portion of their retiree premiums shall submit an Electronic Deduction Authorization Form within sixty (60) days of the effective date of the event that results in the required premium.

Failure to submit an Electronic Deduction Authorization Form within sixty (60) days shall result in either the rejection of the employee-beneficiary's enrollment application or termination of health benefit plans as of the first day following the last period for which full payment was received by the Fund.

If the Electronic Deduction Authorization Form is submitted after rejection of an enrollment application or termination of health benefit plans, the changes requested in the enrollment application or reinstatement of terminated health benefit plans, respectively, shall be effective retroactively to the effective date of enrollment application changes or the termination date, respectively.

(c) Returned Recurring Electronic Premium Deduction. If an employee-beneficiary's recurring electronic deduction is returned by the Employees' Retirement System of the State of Hawaii or financial institution, a notice from the Fund will be sent to the employee-beneficiary. The employee-beneficiary has thirty (30) days from the date of the notice to submit a valid Electronic Deduction Authorization Form. Failure to provide a valid Electronic Deduction Authorization Form within thirty (30) days of the date of the notice will result in termination of health benefit plans as of the first day following the last period for which full payment was made. Health benefit plan(s) may be reinstated if their enrollment has not been terminated within twelve (12) months of the date of the notice of cancellation and the employee-beneficiary submits a valid Electronic Deduction Authorization Form within sixty (60) days from the date of the notice of cancellation. The reinstatement shall be made so that the employee beneficiary and dependent-beneficiaries suffer no break in coverage.

4.15 Overpayments

If an employee-beneficiary is overpaid for a reimbursement, refund, or any other reason, the Fund may automatically withdraw the over-paid amount from the financial account on record for the employee-beneficiary.

5.00 HEALTH AND OTHER BENEFIT PLANS

5.01 Enrollment; Effective Dates of Coverage

(a) New Employee. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary is first eligible as an employee as defined in 87A-1, Hawaii Revised Statutes. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the employee beneficiary is first eligible; or (2) the first day of the first pay period following the date the employee-beneficiary is first eligible; or (3) the first day of the second pay period following the date the employee-beneficiary is first eligible. The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date that the employee-beneficiary is first eligible. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date the employee-beneficiary is first eligible.

(b) Loss of Coverage in a Benefit Plan Offered by the Fund. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for dependent-beneficiaries when the employee-beneficiary loses coverage under the benefit plans offered or sponsored by the Fund because the employee-beneficiary's covering

enrollment was terminated or the employee-beneficiary ceased to be eligible as a dependent-beneficiary. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days after the loss of coverage.

(c) Loss of Coverage in a Non-Fund Health Benefit Plan. An employee-beneficiary who is eligible but not enrolled, may enroll in the health benefit plans offered or sponsored by the Fund, and obtain coverage for eligible dependent-beneficiaries, when the employee-beneficiary's coverage under non-Fund health benefit plans is terminated. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage, sixty (60) days when the termination is from a Medicaid plan. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days, sixty (60) days for Medicaid, after the loss of coverage. The Fund shall determine the required proof documents.

(d) Enrollment Due to Changes in Marital, Partnership or Family Status. An employee-beneficiary who has previously declined coverage in the health benefit plans offered or sponsored by the Fund may enroll in the Fund benefit plans when the employee-beneficiary gains a dependent through a change in marital, partnership or family status, e.g., marriage, entry into a domestic or civil union partnership, birth, adoption, guardianship, or issuance of a qualified medical child support order. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical child support order, which shall be limited to the date of the event. The date of the event shall be:

(1) For marriages the date on the marriage certificate;
(2) For civil unions the date on the civil union certificate;
(3) For domestic partnerships the date the notary notarizes the Declaration of Domestic Partnership;
(4) For births the date of birth;

(5) For adoptions the date of the adoption;
(6) For placement of adoption or guardianships the date of guardianship;
(7) For placement of a foster child the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home; and
(8) For a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.
(9) For dependent-beneficiary joining the employee-beneficiary's household, the date the dependent-beneficiary joins the household.

The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date of the event, except for newborns which is within one hundred eighty (180) days of the birth. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date of the event. The Fund shall determine the required proof documents.

(e) Enrollment or Changes in Enrollment Upon Retirement. An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when that person becomes a retired member of the Employees' Retirement System as defined in 87A-1, Hawaii Revised Statutes. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement provided a completed enrollment application is received by the Fund within sixty (60) days of retirement.

For disability retirement, at the option of the employee-beneficiary, the effective date of coverage shall be the first of the month on or after the employee-beneficiary's date of retirement or the 1st of the month of the date of the Employees' Retirement System disability certification letter provided that a completed enrollment application is received by the Fund within 60 days of certification from the Employees' Retirement System of a disability retirement.

Retired employee beneficiaries shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

(f) Surviving Spouse, Partner, or Child of a Deceased Retiree Not Enrolled in the Fund or an Employee Who was Killed in the Performance of Duty Who Was Not Enrolled in the Fund. A surviving spouse, partner or unmarried child who is eligible as an employee-beneficiary under Rule 3.01(a) may enroll in the health benefit plans offered or sponsored by the Fund. The effective date of coverage shall be the date the retiree passed away or the date the employee was killed in the performance of duty, provided a completed enrollment application is received by the Fund within sixty (60) days of the retiree passing away or within sixty (60) days of the date the employee was killed in the performance of duty for dependents not enrolled at the time of death. Surviving spouses, partners, or unmarried children of a deceased retiree or an employee who was killed in the performance of duty shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the passing away of the retiree or more than sixty (60) days after the date the employee was killed in the performance of duty.

(g) The public employer's premium contributions and employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. The contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period. For example, if an employee-beneficiary's effective date of coverage occurs on any date during the first pay period of a month (first half of a month), the public employer and employee-beneficiary shall make contributions as if the employee-beneficiary had been enrolled in the applicable health benefit plans as of the first day of that first pay period. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. For example, if an employee-beneficiary changes enrollment or coverage during any date during the second pay period of a month (second half of a month), the public employer and employee-beneficiary shall make contributions as if the change in enrollment or coverage had occurred as of the first day of that second pay period.

5.02 Changes in Enrollment; Effective Dates of Coverage

(a) Additions of Dependents Due to Changes in Marital, Partnership, Legal Guardianship, or Family Status. An employee-beneficiary may change his or her enrollment to add coverage for dependent-beneficiaries in the Fund health benefit plans in which the employee-beneficiary is currently enrolled upon the occurrence of any of the following events: marriage, entry into a partnership, birth of a child, adoption of a child, addition of a foster child, the issuance of a qualified medical support order, or when a dependent-beneficiary joins the employee-beneficiary's household. At the option of the employee-beneficiary, the effective date of the change in enrollment shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical support child support order, which shall be limited to the date of the event, provided an enrollment application is filed with the employer for active employee-beneficiaries and to the Fund for retirees within forty five (45) days of the event, except in the event of a birth of a child in which case the enrollment application shall be filed with the employer or in the case of a retired employee-beneficiary with the Fund within one hundred eighty (180) days of the birth.

(1) With respect to the addition of a spouse or civil union partner, as well as dependent(s) of a new spouse or civil union partner, the event date shall be the date indicated on the marriage or civil union certificate.
(2) With respect to the addition of a domestic partner, as well as the dependent(s) of a domestic partner, the event date shall be the date the notary notarizes the Declaration of Domestic Partnership.
(3) With respect to the birth of a child, the event date shall be the birth date.
(4) With respect to the addition of a foster child, the event date shall be the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home.
(5) With respect to the adoption of a child, the event date shall be the date of the adoption (which may occur up to 1 year after the child was initially placed for adoption). For placement of adoption or legal guardianship, the event date shall be the date of guardianship.
(6) With respect to a qualified medical child support order, the event date shall be the date specified in the order, or if no date is specified, the date that the order is issued.

(7) With respect to a dependent-beneficiary joining the employee-beneficiary's household; the event date shall be the date the dependent-beneficiary joined the employee-beneficiary's household if the dependent-beneficiary lived in a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan.

The Fund shall determine the required proof documents for each of the above events.

(b) Deletions of Dependents Due to Changes in Marital, Partnership or Family Status, or Legal Guardianship. An employee-beneficiary shall change his or her enrollment to terminate coverage of dependent-beneficiaries who cease to be eligible for continued enrollment in the Fund health benefit plans upon the occurrence of any of the following events: divorce or dissolution; annulment; legal separation; dissolution or other act ending a partnership; death of a spouse, partner or child; the end of any required coverage of a child under a qualified medical support order; a child ceases to be eligible for coverage under Rule 3.01 or a dependent covered due to legal guardianship turns the age of 18 (age of majority). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Enrollment applications must be filed with the employer or in the cases of retirees to the Fund within forty-five (45) days of the event. Employee-beneficiaries may be responsible for paying all claims incurred, reimbursements received or employer contributions paid for any ineligible person after the event date for enrollment applications filed more than forty five (45) days after the event pursuant to Rule 4.12(c).

The Fund shall determine the required proof documents.

(c) Loss of Eligible Dependent's Coverage. An employee-beneficiary may change enrollment to add an eligible dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when a dependent-beneficiary loses coverage in any health benefit plan. The effective date of the change in enrollment shall be the date that the dependent-beneficiary loses coverage in the health benefit plan, provided an enrollment application is received by the employer or in the case of a retiree by the Fund within forty five (45) days of the loss of coverage, sixty (60) days when the termination is from a Medicaid plan.

Coverage for a dependent-beneficiary may be added at the next open enrollment period when enrollment applications are received after forty five (45) days, sixty (60) days for Medicaid, of the loss of coverage.

The Fund shall determine the required proof documents.

(d) Last Child Becomes Ineligible. An employee-beneficiary may change his or her enrollment in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the last of the employee-beneficiary's children becomes ineligible for coverage as a dependent-beneficiary under the health benefit plans offered or sponsored by the Fund, e.g., when the child reaches the limiting age, as defined in Section 1.02 (unless the child is an adult disabled child under Section 3.01). An enrollment application shall be filed with the employer or in the case of a retiree with the Fund within forty five (45) days of the loss of eligibility. The effective date of the change in enrollment shall be the first day of the first pay period following the loss of eligibility.

(e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:

(1) The employee-beneficiary or dependent-beneficiary moves to a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan. The effective date of the change shall be the first day of the pay period following the employee-beneficiary or dependent-beneficiary's relocation except for retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan.

For retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan, the effective date of the change shall be made prospectively at the end of the month of the relocation or the end of the month in which the EUTF is notified, whichever is later.

(2) The employee-beneficiary is enrolled in a supplemental health benefits plan offered or sponsored by the Fund and loses primary coverage in a Non-Fund health benefits plan. The effective date of the change shall be the date that the employee-beneficiary loses coverage in the Non-Fund health benefits plan. The requirements of Rule 5.01(c) apply, except for the cancellation of the supplemental health benefits plan which will be cancelled upon

notification of the loss of the primary coverage in the Non-Fund health benefits plan.

(3) The employee-beneficiary is enrolled in a health benefits plan sponsored by the Fund and gains coverage under a Non-Fund health benefits plan. The employee-beneficiary may enroll in a supplemental health benefit plan offered or sponsored by the Fund. The effective date of the change shall be the first day of the pay period following the cancellation of the health benefits plan sponsored by the Fund.

(4) With respect to a qualified medical child support order, if an employee-beneficiary is enrolled in a plan whose services are limited to the State of Hawaii and whose dependent subject to the qualified medical child support order lives outside the State of Hawaii, the employee-beneficiary shall be allowed to change their plan selection to one whose services are available to the dependent.

(5) The retired employee-beneficiary enrolls in Medicare Part B. An enrollment application shall be filed within sixty (60) days of the retired employee-beneficiary's Medicare Part B effective date. The effective date of the change shall be the effective date of the retired employee-beneficiary's Medicare Part B or the first of the month following the Fund's receipt of the enrollment application, whichever is later. The retired employee-beneficiary and dependent-beneficiaries will remain in the previous medical and/or prescription drug plan(s) until the effective date of the new medical and/or prescription drug plan(s).

(6) The employee-beneficiary is enrolled in HSTA VB health benefit plans and changes to a bargaining unit (BU) other than 05, may enroll in a non-HSTA VB health benefit plan offered by the Fund. An enrollment application shall be filed within forty five (45) days of the effective date of the BU change. Non-HSTA VB benefit plan options shall be limited to the benefit plan(s) lost under the HSTA VB health benefit plans. If an enrollment application is not received within forty five (45) days of the effective date of the BU change, the employee-beneficiary shall be enrolled in the comparable non-HSTA VB health benefit plan offered by the Fund. The effective date of the change shall be the effective date of the bargaining unit change.

(f) Dependent Not Enrolled in a Fund Medical and/or Prescription Drug Plan Enrolls in Medicare Part B. A retired employee-beneficiary may add coverage for dependent-beneficiaries in the Fund medical and/or

prescription drug plan(s), in which the retired employee-beneficiary is already enrolled when the dependent-beneficiary enrolls in Medicare Part B. An enrollment application shall be filed within sixty (60) days of the dependent-beneficiary's Medicare Part B effective date. The effective date of the addition shall be the effective date of the dependent-beneficiary's Medicare Part B, except when a health insurance carrier only offers a Medicare-only medical plan, in which case the effective date of the addition shall be the dependent-beneficiary's Medicare Part B effective date or the first of the month following the Fund's receipt of the enrollment application, whichever is later. If the health insurance carrier offers a non-Medicare medical and/or prescription drug plan, the dependent-beneficiary will be enrolled in the non-Medicare medical and/or prescription drug plan until the effective date of the Medicare medical and/or prescription drug plan.

The Fund shall determine the required proof documents.

(g) Any change in the public employer's premium contributions and the employee-beneficiary's premium contributions, if any resulting from a change in enrollment or coverage shall begin as of the first day of the pay period in which the effective date of the employee-beneficiary's change in enrollment or coverage occurs. As in Rule 5.01(g), contributions shall not be prorated based on when the employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.03 Mandatory Enrollment in Medicare Part B and Medicare Part D for Retired Employees and Cancellation Due to Failure to Enroll

(a) Retired employee-beneficiaries or dependent-beneficiaries of retirees shall submit proof of enrollment in the federal Medicare Part B medical insurance plan when the employee-beneficiary or dependent-beneficiary becomes eligible to enroll in the federal Medicare Part B medical insurance plan if enrolled in a medical and/or prescription drug plan.

Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of eligibility shall result in loss of medical and/or prescription drug coverage retroactive to the date of Medicare Part B medical insurance plan eligibility.

(b) Employee-beneficiaries who retire and are eligible for Medicare Part B at the time of retirement and their dependent beneficiaries who are eligible

for Medicare Part B at the time of the employee-beneficiary's retirement shall provide proof of enrollment in Medicare Part B at the time of retirement or within sixty (60) days of retirement. Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of retirement shall result in loss of medical and/or prescription drug coverage retroactive to the date of retirement.

(c) Retired employee-beneficiaries and their spouses/partners shall be reimbursed quarterly the cost of their Medicare Part B premiums, including Income Related Monthly Adjustment Amount (IRMAA) Medicare Part B premiums, less penalties. Reimbursements shall be made using direct deposit unless the method of payment is waived by the Fund and another method is determined to be more appropriate.

(1) Medicare Part B premium reimbursements shall be effective the date the Medicare Part B is effective or the first day of the month that the fund receives appropriate proof of enrollment in Medicare Part B and a valid direct deposit agreement, whichever is later. In addition, proof of payment to the Social Security Administration or Centers for Medicare & Medicaid Services is required to begin Medicare Part B reimbursements.

(2) If a retired employee-beneficiary's direct deposit is returned by the financial institution or check is returned as undeliverable, a notice from the Fund will be sent to the retired employee-beneficiary. The retired employee-beneficiary has sixty (60) days from the date of the notice to submit a valid direct deposit agreement or a retiree address change form (returned check) to avoid a break in their reimbursement. Failure to provide a valid direct deposit agreement or a retiree address change form (returned check) within sixty (60) days of the date of the notice will result in cancellation of Medicare Part B premium reimbursements retroactive to the first day of the month of the quarter that the direct deposit was returned or when the check was returned undeliverable. If the reimbursement is cancelled, the retired employee-beneficiary's Medicare Part B premium reimbursements can be reinstated when a valid direct deposit agreement or a retiree address change form (returned check) is received with an effective date of the first day of the month that the valid direct deposit agreement or the retiree address change form (returned check) is received.

(3) Retired employee-beneficiaries and/or their spouses/partners shall provide the Fund appropriate proof of an IRMAA added to their Medicare Part B premium. If proof is submitted to the fund more than two years after the effective date of the IRMAA premium, the fund shall only reimburse for a two year retroactive period, subject to 5.03(c)(1).

(4) Each public employer shall pay to the Fund a contribution equal to the amount paid by the Fund to the retired employee-beneficiaries and their spouses/ partners.

Payment of these reimbursements shall be made only for retired employee-beneficiaries and/or their spouses/partners who are enrolled in the Medicare Part B medical insurance plan and pay their Medicare Part B medical insurance premiums to the Social Security Administration or Centers for Medicare & Medicaid Services.

(d) Retired employee-beneficiaries and dependent-beneficiaries whose medical and/or prescription drug coverages were cancelled due to failure to show proof of enrollment in Medicare Part B may be reinstated in the same medical and/or prescription drug plans upon proof of enrollment in Medicare Part B. The effective date of coverage shall be the later of the effective date of the Medicare Part B coverage or the medical and/or prescription drug coverage enrollment date.

(e) Retired employee-beneficiaries and their dependent-beneficiaries eligible for Medicare shall be enrolled in a Fund Medicare prescription drug plan if they wish to enroll in a Fund retiree prescription drug plan. Exceptions to this Rule include employee-beneficiaries and/or dependent-beneficiaries who reside outside of the Fund's Medicare prescription plan service area.

5.04 Cancellation Due to Failure to Enroll or Failure to Maintain Enrollment in Medicare; Effective Date of Cancellation

(a) If a retired employee-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the retired employee-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund and the medical and/or prescription drug plan coverages for dependent-beneficiaries under that enrollment shall be cancelled.

(b) If a retired employee-beneficiary's dependent-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the dependent-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund shall be cancelled.

(c) If a retired employee-beneficiary and/or dependent-beneficiary fails to enroll in the Fund's Medicare prescription drug plan their enrollment in the prescription drug plans offered or sponsored by the Fund shall be cancelled. Retired employee-beneficiaries and/or their dependent-beneficiaries living outside of the Fund's Medicare prescription drug plan's service area are exempt from this Rule.

(d) The effective date of any cancellation under this rule shall be the date upon which the retired employee-beneficiary or their dependent-beneficiary, as applicable, first became eligible to enroll or ceased to be enrolled in the federal Medicare Part B medical insurance plan. The retired employee-beneficiary or their dependent-beneficiary shall be responsible for paying all claims incurred from the date the retired employee-beneficiary or their dependent-beneficiary became eligible to enroll, but did not enroll.

5.05 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Surviving Spouse's or Partner's Remarriage or Entry into Another Partnership. A surviving spouse's or partner's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the surviving spouse's or partner's remarriage or entry into another partnership. The effective date of the termination shall be the first day of the pay period following the date of the surviving spouse's or partner's remarriage or entry into another partnership. The surviving spouse or partner shall be responsible for paying all claims incurred or for the employer contributions paid from the first day of the pay period following the date of the surviving spouse's or partner's remarriage or entry into a partnership for enrollment applications received more than forty five (45) days after the remarriage or entry into another partnership. Notwithstanding the foregoing, a child that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(5) may continue his or her coverages by filing an enrollment application under Rule 5.01(f). The effective date of coverage shall be the date of termination of coverage due

to the surviving spouse's or partner's remarriage or entry into a partnership.

(b) Termination Due to Child's Loss of Eligibility. A child's enrollment in all benefit plans offered or sponsored by the Fund shall be terminated upon the occurrence of any of the following events:

(1) The child reaches the limiting age, as defined in Section 1.02 and does not qualify as an adult disabled child under Section 3.01; or
(2) The employee-beneficiary fails to complete a legal adoption of the child within twelve (12) months of the date that the child is covered by the Fund's benefit plans; or
(3) The child no longer meets the requirements to be considered an adult disabled child as stated in Section 3.01.

With regards to subsection (1), a child that reaches the limiting age, as defined in Section 1.02. whose coverages were cancelled due to failure to show proof of student certification, may be reinstated with no break in coverage in the same benefit plans upon submission of proof documents within forty five (45) days of the birthdate.

Notwithstanding Rule 5.05 (b)(2), the enrollment of a child placed for adoption shall not be terminated if the employee-beneficiary has custody of and an obligation to support the child under a court order or agreement with a government agency or licensed child placing organization.

Unless provided otherwise by these rules or applicable federal or state law, the effective date of the termination shall be the first day of the pay period following the date of the event or, in an event under Rule 5.05 (b)(2), the date stated in a written notice to the employee-beneficiary.

5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

(a) Reinstatement in Employment. If as a result of an order or award from a court, arbitrator or other entity with proper jurisdiction over the matter, an employee-beneficiary is found to have been wrongfully terminated or suspended and is ordered to be reinstated in state or county employment, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which the employee-beneficiary's coverage was terminated. The effective date of the reinstatement shall be the date specified by the order or award. The employee-beneficiary shall pay the full cost of such

coverage less any contribution paid by the employer on behalf of the employee-beneficiary as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement. If the full cost of such coverage is not paid, the employee-beneficiary shall have the option of having the reinstatement effective upon any of the following dates: (1) the employee-beneficiary's return to employment; or (2) the first day of the first pay period following the employee-beneficiary's return to employment; or (3) the first day of the second pay period following the employee-beneficiary's return to employment. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within forty five (45) days of the date that the employee-beneficiary returns to active duty. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary returns to active duty.

(b) Return From an Authorized Leave of Absence. If an employee-beneficiary returns from an authorized leave of absence ("LOA") during which coverage was not provided by a Fund benefit plan, the employee-beneficiary may be reinstated in the same Fund benefit plans from which coverage was cancelled if the employee-beneficiary files a properly completed enrollment application. At the option of the employee-beneficiary, the reinstatement shall be effective upon any of the following dates: (i) the employee-beneficiary's return from the LOA provided the employee-beneficiary files an enrollment application in accordance with Rule 4.05 within forty five (45) days of his or her return from the LOA, (ii) the first day of the first pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above. If the employee-beneficiary fails to file an enrollment application within forty five (45) days of his or her return to work, the employee-beneficiary shall be eligible to reenroll during the next open enrollment period.

(c) Return From a Leave of Absence Covered by the Family Medical Leave Act (FMLA) Or Uniform Services Employment and Reemployment Rights Act (USERRA). If an employee-beneficiary returns from a leave of absence covered under the FMLA or USERRA and the employee-beneficiary's enrollment in the Fund benefit plans was canceled during that leave of absence, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which coverage was canceled. At the

option of the employee-beneficiary, reinstatement shall be effective upon any of the following dates: (i) the date of the employee-beneficiary's return to work, (ii) the first day of the first pay period following the date of the employee-beneficiary's return to work, or (iii) the first day of the second pay period following the date of the employee-beneficiary's return to work. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within forty five (45) days of the date that the employee-beneficiary returns to work. If the employee-beneficiary fails to make a start date selection, the effective date of coverage shall be the date of the employee-beneficiary's return to work. If the employee-beneficiary fails to file an enrollment application within forty five (45) days of his or her return to work, the reinstatement shall be effective on the first day of the first pay period following the employee-beneficiary's proper filing of the enrollment application.

(d) Enrollment in Medicare by a Retired Employee. If the enrollment of an employee-beneficiary or the coverage of a dependent-beneficiary was terminated due to the employee-beneficiary's or dependent-beneficiary's failure to enroll in the federal Medicare Part B medical insurance plan, upon the employee-beneficiary's or dependent-beneficiary's enrollment in such plan and submission of a proper and complete enrollment application to the Fund, the employee-beneficiary or dependent-beneficiary shall be enrolled in or covered by the Medicare supplemental plan offered by the Fund. The coverage shall be effective on the date specified in Rule 5.03.

(e) Enrollment in Medicare Advantage Plan by a Retired Employee. If the enrollment of a retired employee-beneficiary or their dependent-beneficiary was terminated due to failure to enroll in the Fund's Medicare Advantage plan, their coverage shall be reinstated effective the first of the month in which the Fund or their health insurance carrier receives a properly completed enrollment application.

(f) The public employer's premium contributions and the employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. As in Rule 5.01(g), contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period or on when an

employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.07 Reimbursement of Retired Employee-Beneficiaries and Their Dependent-Beneficiaries Who Relocate Outside of the State of Hawaii

(a) Retired employee-beneficiaries and their dependent-beneficiaries of retirees who relocate outside of the State of Hawaii shall be eligible for reimbursement for premiums paid for personal medical and prescription drug plans issued by companies outside of the State of Hawaii who have also contracted with the Fund to provide medical and prescription drug plans that are only available to State of Hawaii residents.

(b) The reimbursement shall be the lesser of:

(1) The actual cost of the personal medical and prescription drug plan; or
(2) The amount of the state or county contribution for the most comparable medical and prescription drug plan offered by the Fund.

(c) Retired employee-beneficiaries or dependent-beneficiaries shall provide the Fund appropriate proof of premiums paid. Reimbursements are paid by the Fund in arrears on a quarterly basis upon receipt of documentation that the premiums for an individual health insurance policy has been paid by the retired employee-beneficiary. If proof is submitted more than two years after the premiums were paid, the Fund shall only reimburse for a two year retroactive period.

The Fund shall determine the required proof documents.

The Hawaii Employer-Union Health Benefits Trust Fund Board of Trustees Administrative Rules were adopted during a regular meeting of the Board of Trustees on February 19, 2003, which were amended and approved on May 19, 2004, August 25, 2004, September 28, 2005, March 22, 2006, September 26, 2007, August 20, 2008, August 26, 2009, August 4, 2014, December 9, 2015, June 30, 2016, July 25, 2017, June 26, 2018, August 27, 2019, September 29, 2020, and April 27, 2021. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.

Roderick Becker, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED

David Y. Ige
Governor
State of Hawaii

8/10/21

Date Filed, Office of the Lieutenant
Governor

APPROVED AS TO FORM:

Deputy Attorney General

'21 AUG 11 A9:58

LIEUTENANT GOVERNOR'S
OFFICE

3426

EXHIBIT D

CONTRACT FORM AND GENERAL CONDITIONS

STATE OF HAWAII
CONTRACT FOR GOODS AND SERVICES
BASED UPON
COMPETITIVE SEALED PROPOSALS

This Contract, executed on the respective dates indicated below, is effective as of _____, _____, between Hawaii Employer-Union Health Benefits Trust Fund, *(Insert name of state department, agency, board or commission)* State of Hawaii ("STATE"), by its Administrator, *(Insert title of person signing for State)* (hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")), whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813 _____ and _____ ("CONTRACTOR"), a _____ *(Insert corporation, partnership, joint venture, sole proprietorship. or other legal form of the Contractor)* under the laws of the State of _____, whose business address and federal taxpayer identification numbers are as follows: _____

RECITALS

A. The STATE desires to retain and engage the CONTRACTOR to provide the Goods or services, or both, described in this Contract and its attachments, and the CONTRACTOR is Agreeable to providing said goods or services or both.

B. The STATE has issued a request for competitive sealed proposals, and has received and reviewed proposals submitted in response to the request.

C. The solicitation for proposals and selection of the CONTRACTOR were made in accordance with section 103D-303, Hawaii Revised Statutes ("HRS"), Hawaii Administrative Rules, Title 3, Department of Accounting and General Services, Subtitle 11 ("HAR"), Chapter 122, Subchapter 6, and applicable procedures established by the applicable Chief Procurement Officer ("CPO").

D. The CONTRACTOR has been identified as the responsible and responsive offeror whose proposal is the most advantageous for the STATE, taking into consideration price and the evaluation factors set forth in the request.

E. Pursuant to Section 87A-24(7), HRS, the STATE *(Legal authority to enter into this Contract)* is authorized to enter into this Contract.

F. Money is available to fund this Contract pursuant to:

(1) Section 87A-24(7), HRS *(Identify state sources)*

or (2) ---- *(Identify federal sources)*

or both, in the following amounts: State $ _____

Federal $ ----

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the CONTRACTOR agree as follows:

1. Scope of Services. The CONTRACTOR shall, in a proper and satisfactory manner as determined by the STATE, provide all the goods or services, or both, set forth in the request for competitive sealed proposals number RFP No. _____ ("RFP") and the CONTRACTOR's accepted proposal ("Proposal"), both of which, even if not physically attached to this Contract, are made a part of this Contract..

2. Compensation. The CONTRACTOR shall be compensated for goods supplied or services performed, or both, under this Contract in a total amount not to exceed

_____ ($ _____), including approved costs incurred and taxes, at the time and in the manner set forth in the RFP and CONTRACTOR's Proposal.

3. Time of Performance. The services or goods required of the CONTRACTOR under this Contract shall be performed and completed in accordance with the Time of Performance set forth in Attachment-S3, which is made a part of this Contract.

4. Bonds. The CONTRACTOR ☐ is required to provide or ☒ is not required to provide: ☐ a performance bond, ☐ a payment bond, ☐ a performance and payment bond in the amount of N/A DOLLARS ($ _____).

5. Standards of Conduct Declaration. The Standards of Conduct Declaration of the CONTRACTOR is attached to and made a part of this Contract.

6. Other Terms and Conditions. The General Conditions and any Special Conditions are attached to and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. In the event of a conflict among the documents, the order of precedence shall be as follows: (1) this Contract, including all attachments and addenda; (2) the RFP, including all attachments and addenda; and (3) the Proposal.

7. Liquidated Damages. Liquidated damages shall be assessed in the amount of _____ DOLLARS ($ _____) per day, in accordance with the terms of paragraph 9 of the General Conditions.

8. Notices. Any written notice required to be given by any party to this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid. Notice to the STATE shall be sent to the HOPA's address indicated in the Contract. Notice to the CONTRACTOR shall be sent to the CONTRACTOR's address indicated in the Contract. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The CONTRACTOR is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures, on the dates below, to be effective as of the date first above written.

STATE

_____
(Signature)

Derek M. Mizuno
(Print Name)

Administrator
(Print Title)

_____
(Date)

CONTRACTOR

CORPORATE SEAL
(If available)

_____
(Name of Contractor)

_____
(Signature)

_____
(Print Name)

_____ *
(Print Title)

_____
(Date)

APPROVED AS TO FORM:

_____
Deputy Attorney General

*Evidence of authority of the CONTRACTOR'S representative to sign this Contract for the CONTRACTOR must be attached.

STATE OF HAWAII

CONTRACTOR'S STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, CONTRACTOR, the undersigned does declare as follows:

1. CONTRACTOR ☐ is* ☒ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. CONTRACTOR has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. CONTRACTOR has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. CONTRACTOR has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

CONTRACTOR understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

CONTRACTOR

By _____
(Signature)

Print Name _____

Print Title _____

Name of Contractor _____

Date _____

* Reminder to Agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract must be awarded by competitive sealed bidding under section 103D-302, HRS, or a competitive sealed proposal under section 103D-303, HRS. Otherwise, the Agency may not award the Contract unless it posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

Attachment - S1

STATE OF HAWAII

SCOPE OF SERVICES

Attachment - S2

STATE OF HAWAII

COMPENSATION AND PAYMENT SCHEDULE

Attachment – S3

STATE OF HAWAII

TIME OF PERFORMANCE

STATE OF HAWAII

CERTIFICATE OF EXEMPTION FROM CIVIL SERVICE

1. By Heads of Departments Delegated by the Director of the Department of Human Resources Development ("DHRD").*

Pursuant to a delegation of the authority by the Director of DHRD, I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to § 76-16, Hawaii Revised Statutes (HRS).

(Signature) (Date)

Derek M. Mizuno
(Print Name)

Administrator
(Print Title)

* This part of the form may be used by all department heads and the heads of attached agencies to whom the Director of DHRD expressly has delegated authority to certify § 76-16, HRS, civil service exemptions. The specific paragraph(s) of § 76-16, HRS, upon which an exemption is based should be noted in the contract file. If an exemption is based on § 76-16(b)(15), the contract must meet the following conditions:

(1) It involves the delivery of completed work or product by or during a specific time;
(2) There is no employee-employer relationship; and
(3) The authorized funding for the service is from other than the "A" or personal services cost element.

NOTE: Not all attached agencies have received a delegation under § 76-16(b)(15). If in doubt, attached agencies should check with the Director of DHRD prior to certifying an exemption under § 76-16(b)(15). Authority to certify exemptions under §§76-16(b)(2), and 76-16(b)(12), HRS, has not been delegated; only the Director of DHRD may certify §§ 76-16(b)(2),and 76-16(b)(12) exemptions.

2. By the Director of DHRD, State of Hawaii.

I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to §76-16, HRS.

(Signature) (Date)

(Print Name)

(Print Title, if designee of the Director of DHRD)

STATE OF HAWAII

SPECIAL CONDITIONS

GENERAL CONDITIONS

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GENERAL CONDITIONS

1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.

2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

   a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.

   b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.

   c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.

   d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

   e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.

   f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

a. The CONTRACTOR shall secure, at the CONTRACTOR'S own expense, all personnel required to perform this Contract.

b. The CONTRACTOR shall ensure that the CONTRACTOR'S employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the CONTRACTOR, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

5. Conflicts of Interest. The CONTRACTOR represents that neither the CONTRACTOR, nor any employee or agent of the CONTRACTOR, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the CONTRACTOR'S performance under this Contract.

6. Subcontracts and Assignments. The CONTRACTOR shall not assign or subcontract any of the CONTRACTOR'S duties, obligations, or interests under this Contract and no such assignment or subcontract shall be effective unless (i) the CONTRACTOR obtains the prior written consent of the STATE, and (ii) the CONTRACTOR'S assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR'S assignee or subcontractor have been paid. Additionally, no assignment by the CONTRACTOR of the CONTRACTOR'S right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in section 40-58, HRS.

a. Recognition of a successor in interest. When in the best interest of the State, a successor in interest may be recognized in an assignment contract in which the STATE, the CONTRACTOR and the assignee or transferee (hereinafter referred to as the "Assignee") agree that:

(1) The Assignee assumes all of the CONTRACTOR'S obligations;

(2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and

(3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

b. Change of name. When the CONTRACTOR asks to change the name in which it holds this Contract with the STATE, the procurement officer of the purchasing agency (hereinafter referred to as the "Agency procurement officer") shall, upon receipt of a document acceptable or satisfactory to the

Agency procurement officer indicating such change of name (for example, an amendment to the CONTRACTOR'S articles of incorporation), enter into an amendment to this Contract with the CONTRACTOR to effect such a change of name. The amendment to this Contract changing the CONTRACTOR'S name shall specifically indicate that no other terms and conditions of this Contract are thereby changed.

c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.

d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.

7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.

9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.

10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.

11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.

12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.

a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified

period not exceeding sixty (60) days after the order is delivered to the CONTRACTOR, unless the parties agree to any further period. Any such order shall be identified specifically as a stop performance order issued pursuant to this section. Stop performance orders shall include, as appropriate: (1) A clear description of the work to be suspended; (2) Instructions as to the issuance of further orders by the CONTRACTOR for material or services; (3) Guidance as to action to be taken on subcontracts; and (4) Other instructions and suggestions to the CONTRACTOR for minimizing costs. Upon receipt of such an order, the CONTRACTOR shall forthwith comply with its terms and suspend all performance under this Contract at the time stated, provided, however, the CONTRACTOR shall take all reasonable steps to minimize the occurrence of costs allocable to the performance covered by the order during the period of performance stoppage. Before the stop performance order expires, or within any further period to which the parties shall have agreed, the Agency procurement officer shall either:

(1) Cancel the stop performance order; or

(2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.

b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:

(1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and

(2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.

d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

a. Default. If the CONTRACTOR refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency procurement officer may notify the CONTRACTOR in writing of the delay or non-performance and if not cured in ten (10) days or any longer time specified in writing by the Agency procurement officer, such officer may terminate the CONTRACTOR'S right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency procurement officer may procure similar goods or services in a manner and upon the terms deemed appropriate by the Agency procurement officer. The CONTRACTOR shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

b. CONTRACTOR'S duties. Notwithstanding termination of the Contract and subject to any directions from the Agency procurement officer, the CONTRACTOR shall take timely, reasonable, and

necessary action to protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest.

c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.

d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.

e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.

f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

a. Termination. The Agency procurement officer may, when the interests of the STATE so require, terminate this Contract in whole or in part, for the convenience of the STATE. The Agency procurement officer shall give written notice of the termination to the CONTRACTOR specifying the part of the Contract terminated and when termination becomes effective.

b. CONTRACTOR'S obligations. The CONTRACTOR shall incur no further obligations in connection with the terminated performance and on the date(s) set in the notice of termination the CONTRACTOR will stop performance to the extent specified. The CONTRACTOR shall also terminate outstanding orders and subcontracts as they relate to the terminated performance. The CONTRACTOR shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated performance subject to the STATE'S approval. The Agency procurement officer may direct the CONTRACTOR to assign the CONTRACTOR'S right, title, and interest under terminated orders or subcontracts to the STATE. The CONTRACTOR must still complete the performance not terminated by the notice of termination and may incur obligations as necessary to do so.

c. Right to goods and work product. The Agency procurement officer may require the CONTRACTOR to transfer title and deliver to the STATE in the manner and to the extent directed by the Agency procurement officer:

(1) Any completed goods or work product; and

(2) The partially completed goods and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the CONTRACTOR has specifically produced or specially acquired for the performance of the terminated part of this Contract.

The CONTRACTOR shall, upon direction of the Agency procurement officer, protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest. If the Agency procurement officer does not exercise this right, the CONTRACTOR shall use best efforts to sell such goods and manufacturing materials. Use of this paragraph in no way implies that the STATE has breached the Contract by exercise of the termination for convenience provision.

d. Compensation.

(1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.

(2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.

(3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:

(A) Contract prices for goods or services accepted under the Contract;

(B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;

(C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);

(D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the

total Contract price plus the reasonable settlement costs of the CONTRACTOR reduced by the amount of payments otherwise made, the proceeds of any sales of supplies and manufacturing materials under subparagraph 14d(2), and the contract price of performance not terminated.

(4) Costs claimed, agreed to, or established under subparagraphs 14d(2) and 14d(3) shall be in accordance with Chapter 3-123 (Cost Principles) of the Procurement Rules.

15. Claims Based on the Agency Procurement Officer's Actions or Omissions.

a. Changes in scope. If any action or omission on the part of the Agency procurement officer (which term includes the designee of such officer for purposes of this paragraph 15) requiring performance changes within the scope of the Contract constitutes the basis for a claim by the CONTRACTOR for additional compensation, damages, or an extension of time for completion, the CONTRACTOR shall continue with performance of the Contract in compliance with the directions or orders of such officials, but by so doing, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, damages, or an extension of time for completion; provided:

(1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:

(A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;

(B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or

(C) Within such further time as may be allowed by the Agency procurement officer in writing.

(2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;

(3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and

(4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

b. CONTRACTOR not excused. Nothing herein contained, however, shall excuse the CONTRACTOR from compliance with any rules or laws precluding any state officers and CONTRACTOR from acting in collusion or bad faith in issuing or performing change orders which are clearly not within the scope of the Contract.

c. Price adjustment. Any adjustment in the price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

16. Costs and Expenses. Any reimbursement due the CONTRACTOR for per diem and transportation expenses under this Contract shall be subject to chapter 3-123 (Cost Principles), HAR, and the following guidelines:

a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.

b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.

c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.

b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.

c. Prompt payment.

(1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and

(2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.

d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

18. Federal Funds. If this Contract is payable in whole or in part from federal funds, CONTRACTOR agrees that, as to the portion of the compensation under this Contract to be payable from federal funds, the CONTRACTOR shall be paid only from such funds received from the federal government, and shall not be paid from any other funds. Failure of the STATE to receive anticipated federal funds shall not be considered a breach by the STATE or an excuse for nonperformance by the CONTRACTOR.

19. Modifications of Contract.

a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.

b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:

(A) Changes in the work within the scope of the Contract; and

(B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.

d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.

e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.

f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.

g. Head of the purchasing agency approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least $25,000.00 and ten per cent (10%) or more of the initial contract price, must receive the prior approval of the head of the purchasing agency.

h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.

i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.

20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:

(1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;

(2) Method of delivery; or

(3) Place of delivery.

a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By

proceeding with the work, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, or any extension of time for completion.

b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.

c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.

d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:

(1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;

(2) By unit prices specified in the Contract or subsequently agreed upon;

(3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;

(4) In such other manner as the parties may mutually agree; or

(5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.

b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

22. Variation in Quantity for Definite Quantity Contracts. Upon the agreement of the STATE and the CONTRACTOR, the quantity of goods or services, or both, if a definite quantity is specified in this Contract, may be increased by a maximum of ten per cent (10%); provided the unit prices will remain the same except for any price adjustments otherwise applicable; and the Agency procurement officer makes a written determination that such an increase will either be more economical than awarding another contract or that it would not be practical to award another contract.

23. Changes in Cost-Reimbursement Contract. If this Contract is a cost-reimbursement contract, the following provisions shall apply:

a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:

(1) Description of performance (Attachment 1);

(2) Time of performance (i.e., hours of the day, days of the week, etc.);

(3) Place of performance of services;

(4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;

(5) Method of shipment or packing of supplies; or

(6) Place of delivery.

b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.

c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.

d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.

e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.

24. Confidentiality of Material.

a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.

25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.

26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.

27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:

    a. The cost or pricing data, and

    b. A state contract, including subcontracts, other than a firm fixed-price contract.

29. Cost or Pricing Data. Cost or pricing data must be submitted to the Agency procurement officer and timely certified as accurate for contracts over $100,000 unless the contract is for a multiple-term or as otherwise specified by the Agency procurement officer. Unless otherwise required by the Agency procurement officer, cost or pricing data submission is not required for contracts awarded pursuant to competitive sealed bid procedures.

    If certified cost or pricing data are subsequently found to have been inaccurate, incomplete, or noncurrent as of the date stated in the certificate, the STATE is entitled to an adjustment of the contract price, including profit or fee, to exclude any significant sum by which the price, including profit or fee, was increased because of the defective data. It is presumed that overstated cost or pricing data increased the contract price in the amount of the defect plus related overhead and profit or fee. Therefore, unless there is a clear indication that the defective data was not used or relied upon, the price will be reduced in such amount.

30. Audit of Cost or Pricing Data. When cost or pricing principles are applicable, the STATE may require an audit of cost or pricing data.

31. Records Retention.

    (1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

    (2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

32. Antitrust Claims. The STATE and the CONTRACTOR recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the CONTRACTOR hereby assigns to STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

33. Patented Articles. The CONTRACTOR shall defend, indemnify, and hold harmless the STATE, and its officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys fees, and all claims, suits, and demands arising out of or resulting from any claims, demands, or actions by the patent holder for infringement or other improper or unauthorized use of any patented article, patented process, or patented appliance in connection with this Contract. The CONTRACTOR shall be solely responsible for correcting or curing to the satisfaction of the STATE any such infringement or improper or unauthorized use, including, without limitation: (a) furnishing at no cost to the STATE a substitute article, process, or appliance acceptable to the STATE, (b) paying royalties or other required payments to the patent holder, (c) obtaining proper authorizations or releases from the patent holder, and (d) furnishing such security to or making such arrangements with the patent holder as may be necessary to correct or cure any such infringement or improper or unauthorized use.

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.

35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.

36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.

38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.

40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.

41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-355, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.

42. Confidentiality of Personal Information.

a. Definitions.

"Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

(1) Social security number;

(2) Driver's license number or Hawaii identification card number; or

(3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

"Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

b. Confidentiality of Material.

(1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.

(2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

(3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

(4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

(5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.

(6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

(1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.

(2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

(A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;

(B) Access to the personal information will be allowed only as necessary to perform the Contract; and

(C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

d. Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

EXHIBIT E

EVIDENCE OF COVERAGE AND BENEFIT DESCRIPTIONS

Full benefit descriptions are available at the EUTF website:
http://eutf.hawaii.gov/health-life-insurance-providers

EXHIBIT F

BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of _____, between the Hawaii Employer-Union Health Benefits Trust Fund, State of Hawaii (hereinafter the "STATE"), by its Administrator, whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813, and _____ (hereinafter "BUSINESS ASSOCIATE"), a _____, whose business address is as follows: _____.

RECITALS

A. The STATE has entered into a contract with BUSINESS ASSOCIATE and/or procured the following goods and services from BUSINESS ASSOCIATE: _____.

B. BUSINESS ASSOCIATE's contract and/or provision of goods and performance of services may require that: (1) Protected Health Information (defined below) or Electronic Protected Health Information (defined below) be disclosed to or used by BUSINESS ASSOCIATE; (2) BUSINESS ASSOCIATE create, receive, maintain or transmit Protected Health Information or Electronic Protected Health Information on behalf of the STATE; and/or (3) BUSINESS ASSOCIATE be provided or have access to Personal Information (defined below).

C. Both parties are committed to complying with the Privacy and Security Laws (defined below) with respect to Protected Health Information, Electronic Protected Health Information, and Personal Information.

D. This Agreement sets forth the terms and conditions pursuant to which the following will be handled: (1) Protected Health Information and Electronic Protected Health Information that is disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; (2) Protected Health Information and Electronic Protected Health Information that is created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE; and (3) Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE will have access by virtue of a contract with the STATE.

TERMS AND CONDITIONS

1. Introduction: The STATE, as defined in this Agreement, has determined that it is a Covered Entity or a Health Care Component of a Covered Entity under HIPAA (defined below) and the Privacy and Security Rules (defined below). In addition, the STATE is subject to use and disclosure restrictions regarding Personal Information under Act 10 (defined below) and Chapters 487N and 487R, Hawaii Revised Statutes.

   The parties acknowledge that entry into this Agreement is necessary and desirable in order to: (a) protect the privacy and security of Protected Health Information and Electronic Protected Health Information in accordance with the Privacy and Security Laws and because BUSINESS ASSOCIATE is a "business associate" of the STATE

as that term is used in 45 Code of Federal Regulations ("C.F.R.") § 160.103; and (b) protect against the unauthorized use and disclosure of Personal Information that BUSINESS ASSOCIATE has been provided or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

2. Definitions:

a. Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in the Privacy and Security Laws.

b. Act 10. "Act 10" shall mean Act 10, 2008 Session Laws of Hawaii, Special Session.

c. Agreement. "Agreement" shall mean this agreement between STATE and BUSINESS ASSOCIATE and any and all attachments, exhibits and special conditions attached hereto.

d. ARRA. "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, and the rules and regulations promulgated under the ARRA.

e. Breach. "Breach" shall have the meaning set forth in the ARRA.

f. De-identified Information. "De-identified Information" shall have the meaning set forth in 45 C.F.R. §§ 164.514(a)-(b).

g. Electronic Protected Health Information. "Electronic Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Electronic Protected Health Information" is limited to Electronic Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

h. Electronic Transactions Rule. "Electronic Transactions Rule" shall mean the final rule set forth in 45 C.F.R. §§ 160 and 162.

i. HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

j. Individual. "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative under 45 C.F.R. § 164.502(g).

k. Individually Identifiable Health Information. "Individually Identifiable Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103.

l. Personal Information. "Personal Information" shall have the meaning set forth in Section 487N-1, Hawaii Revised Statutes. For purposes of this Agreement, "Personal Information" is limited to Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

m. Ping. "Ping" shall mean a request-response utility or other method used to determine whether a specific Internet Protocol (IP) address or host exists or is accessible.

n. Port Scan. "Port Scan" shall mean a process that sends requests to a host to determine network services that are available on that host.

o. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as the same may be amended from time to time.

p. Privacy and Security Laws. "Privacy and Security Laws" shall include: (1) the provisions of HIPAA that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (2) the Privacy and Security Rules; (3) the provisions of ARRA, including the rules and regulations promulgated under the ARRA, that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (4) Act 10 and, to the extent applicable, Chapters 487N and 487R, Hawai‘i Revised Statutes; and (5) other Federal and State privacy or security statutes and regulations that apply to Protected Health Information, Electronic Protected Health Information, or Personal Information.

q. Protected Health Information. "Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Protected Health Information" is limited to Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

r. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or designee.

s. Security Rule. "Security Rule" shall mean the Health Insurance Reform: Security Standards at 45 C.F.R. Part 160, Part 162, and Part 164, Subparts A and C, as the same may be amended from time to time.

t. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall have the meaning set forth in the ARRA.

3. Obligations and Activities of BUSINESS ASSOCIATE

a. BUSINESS ASSOCIATE agrees to not use or disclose Protected Health Information, Electronic Protected Health Information, and Personal Information other than as permitted or required by this Agreement or as required by law.

b. BUSINESS ASSOCIATE agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information, Electronic Protected Health Information, and Personal Information other than as provided for by this Agreement.

c. BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards (as those terms are defined in the Security Rule) that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the STATE. Without limiting the foregoing, BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards to comply with 45 C.F.R. §§ 164.308, 164.310, and 164.312, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

(i) Required Safeguards. BUSINESS ASSOCIATE shall use all appropriate safeguards to prevent use or disclosure of Protected Health Information received from, or created or received on behalf of, STATE, other than as provided for in this Agreement or as required by law. These safeguards will include, but are not limited to:

(I) Training. Providing annual training to relevant employees, contractors, and subcontractors on how to prevent the improper use or disclosure of Protected Health Information; and updating and repeating training on a regular basis;

(II) Administrative Safeguards. Adopting policies and procedures regarding the safeguarding of Protected Health Information; and enforcing those policies and procedures, including sanctions for anyone not found in compliance;

(III) Technical and Physical Safeguards. Implementing appropriate technical safeguards to protect Protected Health Information, including access controls, authentication, and transmission security; and implementing appropriate physical safeguards to protect Protected Health Information, including workstation security and device and media controls.

d. In accordance with Part V of Act 10, BUSINESS ASSOCIATE agrees to implement: (i) technological safeguards to reduce exposure to unauthorized access to Personal Information, (ii) mandatory training on security awareness topics relating to Personal Information protection for BUSINESS ASSOCIATE's employees, and (iii) confidentiality agreements to be signed by BUSINESS ASSOCIATE's employees. BUSINESS ASSOCIATE further agrees to safeguard Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE.

e. BUSINESS ASSOCIATE agrees to ensure that any agent (including a contractor or subcontractor) to whom it provides Protected Health Information, Electronic Protected Health Information, or Personal Information agrees to the same restrictions and conditions that apply to BUSINESS ASSOCIATE with respect to

such information under this Agreement and the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to ensure that any such agent shall safeguard such Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE. BUSINESS ASSOCIATE agrees to ensure that any such agent shall implement reasonable and appropriate safeguards to protect Protected Health Information.

f. BUSINESS ASSOCIATE agrees to implement reasonable policies and procedures to comply with 45 C.F.R. § 164.316, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

g. BUSINESS ASSOCIATE agrees to provide access to Protected Health Information in the Designated Record Set to STATE or, as directed by STATE, to an Individual to the extent and in the manner required by 45 C.F.R. § 164.524.

h. BUSINESS ASSOCIATE agrees to make Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information that the STATE directs or agrees to in accordance with the requirements of 45 C.F.R. § 164.526.

i. BUSINESS ASSOCIATE agrees to document disclosures of Protected Health Information, disclosures of Electronic Protected Health Information and information related to such disclosures as would be required for STATE to respond to a request by an Individual for an accounting of disclosures of: (1) Protected Health Information in accordance with 45 C.F.R. § 164.528; and (2) Electronic Protected Health Information in accordance Section 13405(c) of the ARRA. BUSINESS ASSOCIATE further agrees to collect and provide to STATE, any and all information that is reasonably necessary for STATE to timely respond to such requests by an Individual for an accounting of disclosures.

j. BUSINESS ASSOCIATE agrees to keep a log of Breaches of Unsecured Protected Health Information in such form and with such information as to enable the STATE to comply with Section 13402(e)(3) of the ARRA and the rules and regulations promulgated under ARRA.

k. BUSINESS ASSOCIATE agrees to keep a complete log of disclosures made of Personal Information in accordance with Section 8(b)(6) of Act 10.

l. BUSINESS ASSOCIATE agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information and Electronic Protected Health Information available to STATE and/or to the Secretary, at reasonable times and places or as designated by the STATE and/or the Secretary, for purposes of determining compliance with the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Personal Information available to STATE, at reasonable times and places or as designated by the STATE, for purposes of determining compliance with this Agreement, Act 10,

and other Federal and State laws regarding the use and disclosure of Personal Information.

m. BUSINESS ASSOCIATE agrees to report to STATE any disclosure or use of Protected Health Information not provided for by this Agreement, of which BUSINESS ASSOCIATE becomes aware, but in no event later than five (5) business days of first learning of any such use or disclosure. BUSINESS ASSOCIATE further agrees to report to STATE any security incidents that are required to be reported by or to the STATE under 45 C.F.R. Part 164, particularly 45 C.F.R. § 164.314. BUSINESS ASSOCIATE agrees that if any of its employees, agents, subcontractors, and/or representatives use and/or disclose Protected Health Information received from, or created or received on behalf of, STATE, or any derivative De-identified Information in a manner not provided for in this Agreement, BUSINESS ASSOCIATE shall ensure that such employees, agents, subcontractors, and/or representatives shall receive training on BUSINESS ASSOCIATE's procedures for compliance with the Privacy Rule, or shall be sanctioned or prevented from accessing any Protected Health Information BUSINESS ASSOCIATE receives from, or creates or receives on behalf of, STATE. Continued use of Protected Health Information in a manner contrary to the terms of this Agreement shall constitute a material breach of this Agreement.

n. If there is a Breach of Unsecured Protected Health Information, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the Breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the Breach; (ii) investigate and report to STATE on the causes of the Breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the Breach that STATE and/or BUSINESS ASSOCIATE are required to make under ARRA including, without limitation, written notices to individuals, notices to the media, and notices to the Secretary or any other governmental entity, all such notices to be made in accordance with all ARRA requirements; (iv) unless the Breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the Breach, including all costs of investigating the Breach, providing all required notices, and otherwise complying with all ARRA requirements; and (v) provide a log of all Breaches of Unsecured Protected Health Information to the STATE no later than twenty (20) calendar days after the end of each calendar year, which log shall include all information that STATE needs in order to comply with Section 13402(e)(3) of the ARRA.

o. If there is a "security breach" regarding Personal Information as that term is defined in Section 487N-1, Hawai'i Revised Statutes, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the security breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the security breach; (ii) investigate and report to STATE on the causes of the security breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in

consultation with STATE, provide all notifications regarding the security breach that STATE and/or BUSINESS ASSOCIATE are required to make under Chapter 487N and other applicable Hawai‘i Revised Statutes; (iv) unless the security breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the security breach, including all costs of investigating the security breach, providing all required notices, and otherwise complying with Chapter 487N and other applicable Hawai‘i Revised Statutes; and (v) assist the State in providing any written report to the legislature or other government entities that is required by Chapter 478N and other applicable Hawai‘i Revised Statutes.

p. BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of: (1) a security breach or disclosure or use of Protected Health Information, Electronic Protected Health Information, or Personal Information by BUSINESS ASSOCIATE in violation of the requirements of this Agreement; and/or (2) a Breach of Unsecured Protected Health Information by BUSINESS ASSOCIATE or any of its officers, employees, or agents (including contractors and subcontractors).

q. BUSINESS ASSOCIATE shall, upon notice from STATE, accommodate any restriction to the use or disclosure of Protected Health Information and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.

r. BUSINESS ASSOCIATE shall comply with any other requirements of the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule not expressly specified in this Agreement, as and to the extent that such requirements apply to business associates under the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule, as they may be amended from time to time.

4. Permitted Uses and Disclosures by BUSINESS ASSOCIATE

a. General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose or use Protected Health Information, Electronic Protected Health Information, and Personal Information to perform functions, activities, or services for, or on behalf of, STATE as specified in this Agreement, provided that such disclosure or use would not violate any Privacy and Security Laws if done by STATE.

b. Specific Use and Disclosure Provisions

(i) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information and Personal Information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.

(ii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE, for disclosures that are

Required By Law, or where BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and the person agrees to notify BUSINESS ASSOCIATE of any instances where the confidentiality of the information has been breached. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Personal Information where such disclosure is permitted by applicable Federal or State laws.

(iii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information to provide Data Aggregation services to STATE as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(iv) BUSINESS ASSOCIATE may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

c. Further Uses Prohibited. Except as provided in sections 4.a and 4.b, above, BUSINESS ASSOCIATE is prohibited from further using or disclosing any information received from STATE, or from any other Business Associate of STATE, for any commercial purposes of BUSINESS ASSOCIATE including, for example, "data mining."

5. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use, or disclosure.

6. Prohibited, Unlawful, or Unauthorized Use and Disclosure of Protected Health Information. BUSINESS ASSOCIATE shall not use or further disclose any Protected Health Information received from, or created or received on behalf of, STATE, in a manner that would violate the requirements of the Privacy Rule, if done by STATE.

7. Indemnity by BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall defend, indemnify and hold harmless STATE and STATE's officers, employees, and agents (including contractors and subcontractors) from and against any and all claims, demands, lawsuits, administrative or other proceedings, judgments, liabilities, damages, losses, fines, penalties, and costs, including reasonable attorneys' fees, that are caused by or arise out of a breach or failure to comply with any provision of this Agreement and/or by a violation of any provision of the Privacy and Security Laws, including the ARRA, by BUSINESS ASSOCIATE or any of BUSINESS ASSOCIATE's officers, employees, or agents (including contractors and subcontractors).

8. Permissible Requests by STATE. STATE shall not request BUSINESS ASSOCIATE to disclose or use Protected Health Information, Electronic Protected Health Information, or Personal Information in any manner that would not be permissible under the Privacy and Security Laws if done by STATE.

9. Standard Electronic Transactions. STATE and BUSINESS ASSOCIATE agree that BUSINESS ASSOCIATE shall, on behalf of STATE, transmit data for transactions that are required to be conducted in standardized format under the Electronic Transactions Rule. BUSINESS ASSOCIATE shall comply with the Electronic Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format. BUSINESS ASSOCIATE shall ensure that any of its subcontractors to whom it delegates any of its duties under its contract with STATE, agrees to conduct and agrees to require its agents or subcontractors to comply with the Electronic Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format.

10. Termination for Cause. In addition to any other remedies provided for by this Agreement, upon STATE's knowledge of a material breach or violation by BUSINESS ASSOCIATE of the terms of this Agreement, STATE may either:

    a. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation, and terminate this Agreement if BUSINESS ASSOCIATE does not cure the breach or end the violation within the time specified by the STATE; or

    b. Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached or violated a material term of this Agreement and cure is not possible; and

    c. If neither termination nor cure is feasible, STATE shall report any violation of the federal Privacy and Security Rules to the Secretary.

11. Effect of Termination.

    a. Upon any termination of this Agreement, until notified otherwise by STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements, and other provisions of this Agreement to: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information.

    b. Upon any termination of this Agreement, STATE shall determine whether it is feasible for BUSINESS ASSOCIATE to return to STATE or destroy all or any part of: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE that BUSINESS ASSOCIATE maintains in any form and shall retain no copies of such information; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information. In connection with the foregoing, upon any termination of the Agreement, BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

c. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is feasible, at STATE's option, BUSINESS ASSOCIATE shall return or destroy such information. If STATE directs that BUSINESS ASSOCIATE return or destroy all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information, it is understood and agreed that BUSINESS ASSOCIATE shall retain no copies of such information. Destruction of Personal Information shall be performed in accordance with Chapter 487R, Hawaii Revised Statutes. Notwithstanding the foregoing, BUSINESS ASSOCIATE shall not destroy any Protected Health Information in less than six (6) years from the date that it is received by BUSINESS ASSOCIATE.

d. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is not feasible or opts not to require the return or destruction of such information, BUSINESS ASSOCIATE shall extend the protections, limitations, requirements, and other provisions of this Agreement to such information for so long as BUSINESS ASSOCIATE maintains such information. STATE understands that BUSINESS ASSOCIATE's need to maintain portions of the Protected Health Information in records of actuarial determinations and for other archival purposes related to memorializing advice provided, can render return or destruction infeasible.

e. The provisions of this Section 11 shall apply with respect to all terminations of this Agreement, for any reason whatsoever, and to any and all Protected Health Information, Electronic Protected Health Information, and Personal Information in the possession or control of any and all agents and subcontractors of BUSINESS ASSOCIATE.

12. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Laws means the section in effect or as amended.

b. Amendment. BUSINESS ASSOCIATE and STATE agree to take all actions necessary to amend this Agreement in order for STATE to comply with the requirements of the Privacy Rule, Security Rule, HIPAA, ARRA, and/or any other Federal or State law that is determined to apply to the Protected Health Information, Electronic Protected Health Information, or Personal Information covered by this Agreement. All amendments shall be in writing and executed by both parties.

c. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under Sections 3, 6, 7, and 8 above, shall survive the termination of this Agreement.

d. Interpretation. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the Privacy and Security Laws, as amended, the Privacy and Security Laws shall control. Where provisions of this

Agreement are different than those mandated in the Privacy or Security Laws but are nonetheless permitted by the Privacy or Security Laws, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the Privacy and Security Laws.

e. Third Parties. This Agreement is solely between BUSINESS ASSOCIATE and the STATE and may be enforced only by BUSINESS ASSOCIATE or the STATE. This Agreement shall not be deemed to create any rights in any third parties or to create any obligations or liabilities of BUSINESS ASSOCIATE or the STATE to any third party.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("STATE")

By _____
Its Administrator

Date: _____, 20____

[*name of business associate*]
("BUSINESS ASSOCIATE")

By _____

Its _____

Date: _____, 20____

APPROVED AS TO FORM:

_____
Deputy Attorney General

EXHIBIT G

SAMPLE 834 FILE

Full File Specifications								
INTERCHANGE CONTROL HEADER								
Line	**Field (element)**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Interchange Control Header	ISA01	B.3	6	ISA*00		No Authorization Information Present	
1	Authorization Information	ISA02	B.3	11	*…….			Spaces are represented by "." for clarity
1	Security Information Qualifier	ISA03	B.4	3	*00		No Security Information Present	
1	Security Information	ISA04	B.4	11	*…….			Spaces are represented by "." for clarity
1	Sender Interchange ID Qualifier	ISA05	B.4	3	*30		US Federal Tax Identification Number to Follow	
1	Sender Interchange ID	ISA06	B.4	10	*990266961		SendersFederalTaxID	
1	Receiver Interchange ID Qualifier	ISA07	B.4 - B.5	3	*	30 01 ZZ	Provider Code	
1	Receiver Interchange ID	ISA08	B.5	10	*	**To be supplied by Provider**	ReceiversFederalTaxID	**Provider supplied Federal Tax Identification Number**
1	Interchange Date	ISA09	B.5	9	*CCYYMMDD			The calendar date the file was created.
1	Interchange Time	ISA10	B.5	5	**HHMM*			The time the file was created.
1	Interchange Control Standards Identifier	ISA11	B.5	2	*U		US EDI Community of ASCX12	
1	Interchange Control Version Number	ISA12	B.5	5	*00401			
1	Interchange Control Number	ISA13	B.5	10	*000000001			
1	Acknowledgement Requested	ISA14	B.6	2	*0			
1	Usage Indicator	ISA15	B.6	2	*	T P	Test Production	
1	Component Element Separator	ISA16	B.6	2	*:	Colon		
FUNCTIONAL GROUP HEADER								
Line	**Field (element)**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
2	Functional Identifier Code	GS01	B.8	5	GS*BE		Benefit Enrollment and Maintenance (834)	
2	Application Sender's Code	GS02	B.8	10	*EUTF		SendersID	
2	Application Receiver's Code	GS03	B.8	10	*	To be assigned	Provider ID Code	**Assigned Provider ID Code**
2	Date	GS04	B.8	9	*CCYYMMDD			The calendar date the file was created.
2	Time	GS05	B.8	5	**HHMM*			The time the file was created.
2	Group Control Number	GS06	B.9	10	*000000001			Control Number: Start with 0000001 and increment
2	Responsible Agency Code	GS07	B.9	2	*X		Accredited Standards Committee X12	
2	Version/Release/Industry Identifier Code	GS08	B.9	11	*004010X095			
TRANSACTION SET HEADER								
Line	**Field (element)**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
3	Transaction Identifier Code	ST01	B.17	6	ST*834		Benefit Enrollment and Maintenance	
3	Transaction Control Number	ST02	B.17	9	*00000001			Control Number: Start with 0000001 and increment
BEGINNING SEGMENT								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
4	Transaction Purpose Code	BGN01	28 - 29	6	BGN*00		First time transaction sent	
4	Transaction Identifier Code	BGN02	29	1/30	*			Identifies particular Transaction set, should increment on each transmission. Start with 01 and increment. Provider used in concatenation: provider, trans_set_control_num , plan_descr, as of date.
4	Transaction Date	BGN03	29	9	*CCYYMMDD			The calendar date the data within the file is effective
4	Transaction Time	BGN04	29	5	*HHMM			
4	Time Code	BGN05	29	2	*HS			Hawaii Daylight Time
4	Reference Identification	BGN06	29	0	*			Not Used
4	Reference Identification	BGN07	29	0	*			Not Used
4	Action Code	BGN08	29	1	*	4 (Verify - Full) 2 (Change - Trans)		
TRANSACTION SET POLICY NUMBER								
5	Entity Identification Qualifier	REF01	32	6	REF*38		Master Policy Number	
5	Entity Identification	REF02	33	9	*PolicyNumber		Based on Provider and Group Number.	Same as REF01 IL Provider Group Policy
FILE EFFECTIVE DATE								
6	Date/Time Qualifier	DTP01	34	3	DTP*303			
6	Date/Time Period Format Qualifier	DTP02	34	2	*D8			
6	Date/Time Period	DTP03	34	8	*CCYYMMDD			
SPONSOR NAME								
7	Sponsor Entity ID Code	N101	35	5	N1*P5		Plan Sponsor	
7	Sponsor Entity Name	N102	36	26	*EUTF		EmployerGroupName	
7	Sponsor Entity ID Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
7	Sponsor Entity Identification Code	N104	36	10	*990266961			
PAYOR								
8	Insurer Identity Code	N101	35	5	N1*IN		Insurer	
8	Insurer Identity Name	N102	36	5	*	**To be supplied by Provider**	Provider Identity Name	**Provider supplied Identity Name**
8	Insurer Identification Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
8	Insurer Identification Code	N104	36	10	*	**To be supplied by Provider**		**Provider supplied Federal Tax Identification Number**
DETAIL								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Subscriber Indicator	INS01	44	5	INS*	Y N	Yes - Subscriber No - Not Subscriber	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Individual Relationship Code	INS02	44 - 45	3	*	18 01 19 23 53	Subscriber Spouse Child Sponsored Dependent - Not Used Life Partner	
1	Maintenance Type Code	INS03	45	4	*30		Audit or Compare	
1	Maintenance Reason Code	INS04	46 - 47	3	*XN		Notification Only - Used in complete enrollment transmissions. Used when INS03 equal to 030.	
1	Benefit Status Code	INS05	47 - 48	2	*	A C S T	Active COBRA - Not Used Surviving Insured Tax Equity and Fiscal Responsibility Act (TEFRA) - Not Used	
1	Medicare Plan Code	INS06	48	2	*	C A B Blank	C - MedA and MedB (Not used) A - MedA (Not used) B - MedB Blank - None	
1	COBRA Qualifying Event Code	INS07	48	2	*	**Not Used**	**No value is passed**	
1	Employment Status Code	INS08	49	3	*	AC AO AU L1 RT FT	Active - Not Used Active Military - Overseas - Not Used Active Military - USA - Not Used Leave of Absence - Not Used Retired Full Time	
1	Student Status Code	INS09	49	2	*	F Blank	Full-time Not a student	
1	Handicap Indicator Code	INS10	49	2	*	Blank Y	Not Handicapped Handicapped	
1	Date Time Qualifier	INS11	50	3	*D8		Date Expressed in Format CCYYMMDD	
1	Member Date of Death	INS12	50	9	*CCYYMMDD			
2	Subscriber Number	REF01	51	6	REF*0F		Subscriber Number	Loop 2000, Data Element 128
2	Subscriber Identifier	REF02	52	10	*SSN			
3	Subscriber Number	REF01	53	6	REF*IL		Member Policy Number or Medical plan code (CVS only)	Loop 2000, Data Element 128

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Subscriber Identifier	REF02	53	10	*Member Policy Number		For CVS, this reports Medical plan code for MOOP	Uses Master Policy Number Same as REF01 38
4	Member Identification Number Qualifier	REF01	55 - 56	6	REF*DX		Billing Location	Loop 2000, Data Element 128
4	Member Identification Division Number	REF02	56	5	*Dept			
5	Member Identification Number Qualifier	REF01	55 - 56	6	REF*17		Bargaining Unit	Loop 2000/Loop 2300, Data Element 128
5	Member Identification Division Number	REF02	56	5	*Bargaining Unit			
6	Member Identification Number Qualifier	REF01	55-56	6	REF*F6		Health Insurance Claim (HIC) Number	To be sent for medical plan only
6	Member Identification Division Number	REF02	56	30	*Member HICN		Use when reporting Medicare eligibility for a member	Loop 2000, Data Element 128
7	Subscriber Number	REF01	55 - 56	6	REF*23		Employee ID	Loop 2000, Data Element 128
7	Subscriber Identifier	REF02	56	10	*Employee ID			
8	Subscriber Number	REF01	152 - 153	6	REF*6O		Dependent SSN	Loop 2320, Data Element 128
8	Subscriber Identifier	REF02	153	10	*Dependent SSN			
9	Subscriber Number	REF01	152 - 153	6	REF*Q4		VEBA Grandfather Status	Loop 2320, Data Element 128
9	Subscriber Identifier	REF02	153	10	*Y or N		Y - VEBA Grandfather Member N - Not VEBA Grandfather Member	
10	Member Event Date Qualifier	DTP01	59 - 60	7	DTP*	303 338 339 350	Maintenance Effective Date Medicare B Begin Date Medicare B End Date Medical plan code (CVS file only)	Loop 2000, Data Element 374
10	Member Event Date Format Qualifier	DTP02	60	3	*D8		Date Expressed in Format CCYYMMDD	
10	Member Event Date	DTP03	60	9	*CCYYMMDD			
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*IL		Insured or Subscriber	Loop 2100, Data Element 98
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
11	Member Last Name	NM103	62, 81 - 82	1/35	*LastName			
11	Member First Name	NM104	62, 81 - 82	11	*FirstName			
11	Member Middle Name	NM105	62, 81 - 82	2	*MiddleInitial			
11	Name Prefix	NM106	62, 81 - 82	3	*	Not Used	**No value is passed**	
11	Name Suffix	NM107	62, 81 - 82	3	*	JR SR Not Used		
11	Member Identification Number Qualifier	NM108	62, 81 - 82	3	*34		Social Security Number	
11	Member Identification Number	NM109	62, 81 - 82	10	*SSN			
12	Member Residence Street Address - 1	N301	67	53	N3*SubscriberStreetAddress1			
12	Member Residence Street Address - 2	N302	67	51	*SubscriberStreetAddress2			
13	Member Residence City	N401	68	19	N4*SubscriberCityName			
13	Member Residence State	N402	68	3	*SubscriberStateAbbreviationCode			
13	Member Residence Zip Code - 1	N403	69	6	*SubscriberZipCode1			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
13	Member Residence Zip Code - 2	N403	69	4	*SubscriberZipCode2*			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Demographic Date Format Qualifier	DMG01	70	6	DMG*D8		Date Expressed in Format CCYYMMDD	
14	Member Birth Date	DMG02	71	9	**CCYYMMDD*		Birth date	
14	Member Gender Code	DMG03	71	2	*	F M	Female Male	
14	Member Martial Status	DMG04	71	1	*	I M B	Single Married Domestic Partner	
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*31		Postal Mailing Address	Optional only if subscriber has separate mailing address
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
12	Member Residence Street Address - 1	N301	67	53	N3**SubscriberStreetAddress1*			
12	Member Residence Street Address - 2	N302	67	51	**SubscriberStreetAddress2*			
13	Member Residence City	N401	68	19	N4**SubscriberCityName*			
13	Member Residence State	N402	68	3	**SubscriberStateAbbreviationCode*			
13	Member Residence Zip Code - 1	N403	69	6	**SubscriberZipCode1*			
13	Member Residence Zip Code - 2	N403	69	4	*SubscriberZipCode2*			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
15	Member Coverage Maintenance Type Code	HD01	128 - 129	6	HD*030		Audit or Compare	
15	Member Coverage Type Code	HD03	129 - 130	4	*	DEN HLT LIF CRO PDG VIS	Dental Health Life Ins Chiro Prescription Drug Vision	
15	Plan coverage description	HD04	130	6	*		Benefit Plan	If required by insurer

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
15	Member Coverage Level Code	HD05	130 - 131	4	*	EMP FAM TWO CHD ESP	Employee Only Family Two Party Children Only Employee + Spouse	
16	Member Coverage Date Qualifier	DTP01	132 - 133	7	DTP*303		Maintenance Effective Date	Loop 2300, Data Element 374
16	Member Coverage Date Format Qualifier	DTP02	133	3	*D8		Date Expressed in Format CCYYMMDD	
16	Member Coverage Date	DTP03	134	9	**CCYYMMDD*			
TRANSACTION SET TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Transaction Segment Count	SE01	158	13	SE**TotalNumber*			Number of segments in transaction set
1	Transaction Set Control Number	SE02	158	10	**Same number as Header Control Number*			
FUNCTIONAL GROUP TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Number of Transaction Sets Included	GE01	B.10	9	GE**TotalNumber*			Number of transaction sets
1	Group Control Number	GE02	B.10	10	**Same number as Header Control Number*			
INTERCHANGE CONTROL TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Number of Included Functional Groups	IEA01	B.7	9	IEA**TotalNumber*			Number of functional groups
1	Interchange Control Number	IEA02	B.7	10	**Same number as Header Control Number*			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Transactional File Specifications							
INTERCHANGE CONTROL HEADER							
Line	**Field (element)**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Interchange Control Header	ISA01	B.3	6	ISA*00		No Authorization Information Present	
1	Authorization Information	ISA02	B.3	11	*…….			Spaces are represented by "." for clarity
1	Security Information Qualifier	ISA03	B.4	3	*00		No Security Information Present	
1	Security Information	ISA04	B.4	11	*…….			Spaces are represented by "." for clarity
1	Sender Interchange ID Qualifier	ISA05	B.4	3	*30		US Federal Tax Identification Number to Follow	
1	Sender Interchange ID	ISA06	B.4	10	*990266961		SendersFederalTaxID	
1	Receiver Interchange ID Qualifier	ISA07	B.4 - B.5	3	*	30 01 ZZ	Provider Code	
1	Receiver Interchange ID	ISA08	B.5	10	*	**To be supplied by Provider**	ReceiversFederalTaxID	**Provider supplied Federal Tax Identification Number**
1	Interchange Date	ISA09	B.5	9	*CCYYMMDD			The calendar date the file was created.
1	Interchange Time	ISA10	B.5	5	**HHMM*			The time the file was created.
1	Interchange Control Standards Identifier	ISA11	B.5	2	*U		US EDI Community of ASCX12	
1	Interchange Control Version Number	ISA12	B.5	5	*00401			
1	Interchange Control Number	ISA13	B.5	10	*000000001			
1	Acknowledgement Requested	ISA14	B.6	2	*0			
1	Usage Indicator	ISA15	B.6	2	*	T P	Test Production	
1	Component Element Separator	ISA16	B.6	2	*:	Colon		
FUNCTIONAL GROUP HEADER								
Line	**Field (element)**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
2	Functional Identifier Code	GS01	B.8	5	GS*BE		Benefit Enrollment and Maintenance (834)	
2	Application Sender's Code	GS02	B.8	10	*EUTF		SendersID	
2	Application Receiver's Code	GS03	B.8	10	*	To be assigned	Provider ID Code	**Assigned Provider ID Code**
2	Date	GS04	B.8	9	*CCYYMMDD			The calendar date the file was created.
2	Time	GS05	B.8	5	**HHMM*			The time the file was created.
2	Group Control Number	GS06	B.9	10	*000000001			Control Number: Start with 0000001 and increment
2	Responsible Agency Code	GS07	B.9	2	*X		Accredited Standards Committee X12	
2	Version/Release/Industry Identifier Code	GS08	B.9	11	*004010X095			
TRANSACTION SET HEADER								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Transaction Identifier Code	ST01	B.17	6	ST*834		Benefit Enrollment and Maintenance	
3	Transaction Control Number	ST02	B.17	9	*00000001			Control Number: Start with 0000001 and increment
BEGINNING SEGMENT								
4	Transaction Purpose Code	BGN01	28 - 29	6	BGN*00		First time transaction sent	
4	Transaction Identifier Code	BGN02	29	1/30	*			Identifies particular Transaction set, should increment on each transmission. Start with 01 and increment. Provider used in concatenation: provider, trans_set_control_num , plan_descr, as of date.
4	Transaction Date	BGN03	29	9	*CCYYMMDD			The calendar date the data within the file is effective
4	Transaction Time	BGN04	29	5	**HHMM*			
4	Time Code	BGN05	29	2	**HS*			Hawaii Daylight Time
4	Reference Identification	BGN06	29	0	*			Not Used
4	Reference Identification	BGN07	29	0	*			Not Used
4	Action Code	BGN08	29	1	*	4 (Verify - Full) 2 (Change - Trans)		
TRANSACTION SET POLICY NUMBER								
5	Entity Identification Qualifier	REF01	32	6	REF*38		Master Policy Number	
5	Entity Identification	REF02	33	9	**PolicyNumber*		Based on Provider and Group Number.	Same as REF01 IL Provider Group Policy
FILE EFFECTIVE DATE								
6	Date/Time Qualifier	DTP01	34	3	DTP*303			
6	Date/Time Period Format Qualifier	DTP02	34	2	*D8			
6	Date/Time Period	DTP03	34	8	*CCYYMMDD			
SPONSOR NAME								
7	Sponsor Entity ID Code	N101	35	5	N1*P5		Plan Sponsor	
7	Sponsor Entity Name	N102	36	26	*EUTF		EmployerGroupName	
7	Sponsor Entity ID Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
7	Sponsor Entity Identification Code	N104	36	10	*990266961			
PAYOR								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

8	Insurer Identity Code	N101	35	5	N1*IN		Insurer	
8	Insurer Identity Name	N102	36	5	*	**To be supplied by Provider**	Provider Identity Name	**Provider supplied Identity Name**
8	Insurer Identification Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
8	Insurer Identification Code	N104	36	10	*	**To be supplied by Provider**		**Provider supplied Federal Tax Identification Number**
DETAIL								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Subscriber Indicator	INS01	44	5	INS*	Y N	Yes - Subscriber No - Not Subscriber	
1	Individual Relationship Code	INS02	44 - 45	3	*	18 01 19 23 53	Subscriber Spouse Child Sponsored Dependent - Not Used Life Partner	
1	Maintenance Type Code	INS03	45	4	*	001 021 024 025	Change Addition Cancellation or Termination Reinstatement - Not Used	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

1	Maintenance Reason Code	INS04	46 - 47	3	*	02 05 20 32 01 03 07 08 11 21 31 15 25 33 28 AI 04 22 29 14 41 XT 43	Birth Adoption Active - Not Used Marriage Divorce Death Termination of Benefits Termination of Employment Surviving Spouse - Not Used Disability - Not Used Legal separation - Not Used PCP Change - Not Used Change in Identifying Data (e.g. name) Personal Data Initial Enrollment No Reason Given Retirement Plan Change Benefit Selections Voluntary Withdrawal Re-enrollment Transfer Change of Address	AI used when reason is data correction
1	Benefit Status Code	INS05	47 - 48	2	*	A C S T	Active COBRA - Not Used Surviving Insured Tax Equity and Fiscal Responsibility Act (TEFRA) - Not Used	
1	Medicare Plan Code	INS06	48	2	*	C A B Blank	C - MedA and MedB (Not used) A - MedA (Not used) B - MedB Blank - None	Any new values sent on transaction file
1	COBRA Qualifying Event Code	INS07	48	2	*	**Not Used**	**No value is passed**	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

1	Employment Status Code	INS08	49	3	*	AC AO AU L1 RT TE FT	Active - Not Used Active Military - Overseas - Not Used Active Military - USA - Not Used Leave of Absence - Not Used Retired Terminated Full Time	
1	Student Status Code	INS09	49	2	*	F Blank	Full-time Not a student	Any new values sent on transaction file
1	Handicap Indicator Code	INS10	49	2	*	Blank Y	Not Handicapped Handicapped	Any new values sent on transaction file
1	Date Time Qualifier	INS11	50	3	*D8		Date Expressed in Format CCYYMMDD	
1	Member Date of Death	INS12	50	9	*CCYYMMDD*			
2	Subscriber Number	REF01	51	6	REF*0F		Subscriber Number	Loop 2000, Data Element 128
2	Subscriber Identifier	REF02	52	10	*SSN*			
3	Subscriber Number	REF01	53	6	REF*IL		Member Policy Number or Medical Plan Code (CVS only)	Loop 2000, Data Element 128
3	Subscriber Identifier	REF02	53	10	*Member Policy Number*		For CVS, this reports Medical plan code for MOOP	Uses Master Policy Number Same as REF01 38
4	Member Identification Number Qualifier	REF01	55 - 56	6	REF*DX		Billing Location	Loop 2000, Data Element 128
4	Member Identification Division Number	REF02	56	5	*Dept*			Any new values sent on transaction file
5	Member Identification Number Qualifier	REF01	55 - 56	6	REF*17		Bargaining Unit	Loop 2000/Loop 2300, Data Element 128 **To be sent with every record**
5	Member Identification Division Number	REF02	56	5	*Bargaining Unit*			
6	Member Identification Number Qualifier	REF01	55-56	6	REF*F6		Health Insurance Claim (HIC) Number	To be sent for medical plan only
6	Member Identification Division Number	REF02	56	30	*Member HICN*		Use when reporting Medicare eligibility for a member	Loop 2000, Data Element 128
7	Subscriber Number	REF01	55 - 56	6	REF*23		Employee ID	Loop 2000, Data Element 128
7	Subscriber Identifier	REF02	56	10	*Employee ID*			
8	Subscriber Number	REF01	152 - 153	6	REF*6O		Dependent SSN	Loop 2320, Data Element 128
8	Subscriber Identifier	REF02	153	10	*Dependent SSN*			
9	Subscriber Number	REF01	152 - 153	6	REF*Q4		VEBA Grandfather Status	Loop 2320, Data Element 128
9	Subscriber Identifier	REF02	153	10	*Y or N		Y - VEBA Grandfather Member N - Not VEBA Grandfather Member	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

10	Member Event Date Qualifier	DTP01	59 - 60	7	DTP*	340 341 356 357 303 348 349 360 361 286 338 339 350	COBRA Begin - Not Used COBRA End - Not Used Eligibility Begin - sent if add Eligibility End - sent if term Maintenance Effective - sent if changed Benefit Begin - sent if add Benefit End - sent if term Disability Begin - sent if disabled changed to "yes" Disability End - sent if disabled changed from "yes" Retirement - sent if employment status changed to retired Medicare B Begin Date Medicare B End Date Medical plan code (CVS file only)	Loop 2000, Data Element 374 Eligibility and benefit dates handled in concert - when one changes the other changes. Not found on EUTF Full File even though it's in the file specification
10	Member Event Date Format Qualifier	DTP02	60	3	*D8		Date Expressed in Format CCYYMMDD	Not found on EUTF Full File even though it's in the file specification
10	Member Event Date	DTP03	60	9	*CCYYMMDD*			Not found on EUTF Full File even though it's in the file specification
11	Member Entity Identifier Code	NM101	62, 81	6	NM1*	IL 70 74	Insured or Subscriber Corrected Name or Demographics Changed Corrected Insured	Loop 2100, Data Element 98 IL - Use this code for enrolling a new member or updating a member with no change in identifying information. 74 - Use this code if this transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in loop 2100B. 70 - Use this code if correcting identifying or demographic information on a member enrolled. If only demographic information is being corrected, NM101 in Loop 2100A will be IL.
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
11	Member Last Name	NM103	62, 81 - 82	1/35	*LastName*			
11	Member First Name	NM104	62, 81 - 82	11	*FirstName*			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

11	Member Middle Name	NM105	62, 81 - 82	2	**MiddleInitial*			
11	Name Prefix	NM106	62, 81 - 82	3	*	Not Used	**No value is passed**	
11	Name Suffix	NM107	62, 81 - 82	3	*	JR SR Not Used		
11	Member Identification Number Qualifier	NM108	62, 81 - 82	3	*34		Social Security Number	
11	Member Identification Number	NM109	62, 81 - 82	10	**SSN*			
12	Member Residence Street Address - 1	N301	67	53	N3**SubscriberStreetAddress1*			
12	Member Residence Street Address - 2	N302	67	51	**SubscriberStreetAddress2*			
13	Member Residence City	N401	68	19	N4**SubscriberCityName*			
13	Member Residence State	N402	68	3	**SubscriberStateAbbreviationCode*			
13	Member Residence Zip Code - 1	N403	69	6	**SubscriberZipCode1*			
13	Member Residence Zip Code - 2	N403	69	4	*SubscriberZipCode2*			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Demographic Date Format Qualifier	DMG01	70	6	DMG*D8		Date Expressed in Format CCYYMMDD	
14	Member Birth Date	DMG02	71	9	**CCYYMMDD*		Birth date	
14	Member Gender Code	DMG03	71	2	*	F M	Female Male	
14	Member Martial Status	DMG04	71	1	*	I M B	Single Married Domestic Partner	If marital status not included then transmitting old birth date and sex.
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*31		Postal Mailing Address	Optional only if subscriber has separate mailing address
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
12	Member Residence Street Address - 1	N301	67	53	N3**SubscriberStreetAddress1*			
12	Member Residence Street Address - 2	N302	67	51	**SubscriberStreetAddress2*			
13	Member Residence City	N401	68	19	N4**SubscriberCityName*			
13	Member Residence State	N402	68	3	**SubscriberStateAbbreviationCode*			
13	Member Residence Zip Code - 1	N403	69	6	**SubscriberZipCode1*			
13	Member Residence Zip Code - 2	N403	69	4	*SubscriberZipCode2*			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Disability Type Code	DSB01	124-125		DSB*	3 4	New Disability No New Disability	
14	Member Disability Date Qualifier	DTP01	126 - 127	7	DTP*	360 361	Disability Begin Disability End	Loop 2200, Data Element 374

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

14	Member Disability Date Format Qualifier	DTP02	126	3	*D8		Date Expressed in Format CCYYMMDD	
14	Member Disability Date	DTP03	126	9	*CCYYMMDD			
15	Member Coverage Maintenance Type Code	HD01	128 - 129	6	HD*	001 021 024 025 030	Change Addition Cancellation or Termination Reinstatement - Not Used Audit or Compare	
15	Member Coverage Type Code	HD03	129 - 130	4	*	DEN HLT LIF CRO PDG VIS	Dental Health Life Ins Chiro Prescription Drug Vision	
15	Plan coverage description	HD04	130	6	*		Benefit Plan	**To be sent with every record**
15	Member Coverage Level Code	HD05	130 - 131	4	*	EMP FAM TWO CHD ESP	Employee Only Family Two Party Children Only Employee + Spouse	
16	Member Coverage Date Qualifier	DTP01	132 - 133	7	DTP*	303 348 349	Maintenance Effective Date Benefit Begin - Audit Action 'A'dd Benefit End - Audit Action 'T'er	Loop 2300, Data Element 374
16	Member Coverage Date Format Qualifier	DTP02	133	3	*D8		Date Expressed in Format CCYYMMDD	
16	Member Coverage Date	DTP03	134	9	*CCYYMMDD			
TRANSACTION SET TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Transaction Segment Count	SE01	158	13	SE**TotalNumber*			Number of segments in transaction set including ST and SE segments
1	Transaction Set Control Number	SE02	158	10	**Same number as Header Control Number*			
FUNCTIONAL GROUP TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Number of Transaction Sets Included	GE01	B.10	9	GE**TotalNumber*			Number of transaction sets
1	Group Control Number	GE02	B.10	10	**Same number as Header Control Number*			
INTERCHANGE CONTROL TRAILER								
Line	**Field**	**Ref. Des.**	**Ref. Page**	**Length**	**Contents**	**Valid Values**	**Description**	**Note**
1	Number of Included Functional Groups	IEA01	B.7	9	IEA**TotalNumber*			Number of functional groups

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

1	Interchange Control Number	IEA02	B.7	10	**Same number as Header Control Number*			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

834 Benefit Enrollment and Maintenance

Functional Group ID=BE

Introduction:

This X12 Transaction Set contains the format and establishes the data contents of the Benefit Enrollment and Maintenance Transaction Set (834) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to establish communication between the sponsor of the insurance product and the payer. Such transaction(s) may or may not take place through a third party administrator (TPA). For the purpose of this standard, the sponsor is the party or entity that ultimately pays for the coverage, benefit or product. A sponsor can be an employer, union, government agency, association, or insurance agency. The payer refers to an entity that pays claims, administers the insurance product or benefit, or both. A payer can be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Champus, etc.), or an entity that may be contracted by one of these former groups. For the purpose of the 834 transaction set, a third party administrator (TPA) can be contracted by a sponsor to handle data gathering from those covered by the sponsor if the sponsor does not elect to perform this function itself.

Heading:

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
M	0050	ISA	Interchange Control Header	M	1		
	0075	GS	Functional Group Header	O	1		
M	0100	ST	Transaction Set Header	M	1		
M	0200	BGN	Beginning Segment	M	1		
	0300	REF	Transaction Set Policy Number	O	1		
	0400	DTP	File Effective Date	O	>1		
	0600	QTY	Transaction Set Control Totals	O	3		n1
			LOOP ID - 1000A			1	
M	0700	N1	Sponsor Name	M	1		n2
			LOOP ID - 1000B			1	
M	0700	N1	Payer	M	1		
			LOOP ID - 1000C			2	
	0700	N1	TPA/Broker Name	O	1		

Detail:

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
			LOOP ID - 2000			>1	
Must Use	0100	INS	Member Level Detail	O	1		n3
M	0200	REF	Subscriber Identifier	M	1		n4
	0200	REF	Member Supplemental Identifier	O	13		
	0250	DTP	Member Level Dates	O	24		
			LOOP ID - 2100A			1	
M	0300	NM1	Member Name	M	1		
	0400	PER	Member Communications Numbers	O	1		
	0500	N3	Member Residence Street Address	O	1		
	0600	N4	Member City, State, ZIP Code	O	1		
	0800	DMG	Member Demographics	O	1		
	1000	EC	Employment Class	O	>1		

	1100	ICM	Member Income	O	1		
	1200	AMT	Member Policy Amounts	O	7		
	1500	LUI	Member Language	O	>1		
			LOOP ID - 2100C			1	
	0300	NM1	Member Mailing Address	O	1		
	0500	N3	Member Mail Street Address	O	1		
	0600	N4	Member Mail City, State, ZIP Code	O	1		
			LOOP ID - 2200			>1	
	2000	DSB	Disability Information	O	1		
	2100	DTP	Disability Eligibility Dates	O	2		
			LOOP ID - 2300			99	
M	2600	HD	Health Coverage	M	1		
M	2700	DTP	Health Coverage Dates	M	6		
	2800	AMT	Health Coverage Policy	O	9		
	2900	REF	Health Coverage Policy Number	O	14		
			LOOP ID - 2310			30	
	3100	LX	Provider Information	O	1		n5
	3200	NM1	Provider Name	O	1		n6
			LOOP ID - 2320			5	
	4000	COB	Coordination of Benefits	O	1		
	4050	REF	Additional Coordination of Benefits Identifiers	O	4		
	4070	DTP	Coordination of Benefits Eligibility Dates	O	2		
			LOOP ID - 2330			3	
	4100	NM1	Coordination of Benefits Related Entity	O	1		
	6880	LS	Additional Reporting Categories	O	1		
			LOOP ID - 2700			>1	
	6881	LX	Member Reporting Categories	O	1		
			LOOP ID - 2750			1	
	6882	N1	Reporting Category	O	1		
	6883	REF	Reporting Category Reference	O	1		
	6884	DTP	Reporting Category Date	O	1		
	6885	LE	Additional Reporting Categories Loop Termination	O	1		
M	6900	SE	Transaction Set Trailer	M	1		
	6915	GE	Functional Group Trailer	O	1		
	6930	IEA	Interchange Control Trailer	O	1		

Transaction Set Notes

1. The QTY segment is used to record the total number of subscribers and dependents in the transaction set.
2. At least one iteration of loop 1000 is required to identify the sender or receiver.
3. A Subscriber is a person who elects the benefits and is affiliated with the employer or the insurer. A Dependent is a person who is affiliated with the subscriber, such as a spouse, child, etc., and is therefore entitled to benefits. Subscriber information must come before dependent information. The INS segment is used to note if information being submitted is subscriber information or dependent information.
4. The Subscriber Identifier REF segment is required to link the dependent(s) to the subscriber.
5. Loop 2310 contains information about the primary care providers for the subscriber or the dependent.
6. Medicare Advantage Products require the use of the Health Insurance Claim Number(HICN). The use of Social Security Number is not acceptable.

Segment: **ISA** **Interchange Control Header**
Position: 0050
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:
Notes:

Notes:
1. All positions within each of the data elements must be filled.

2. For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.

3. The first element separator defines the element separator to be used through the entire interchange.

4. The ISA segment terminator defines the segment terminator used throughout the entire interchange.
Example: ISA*00* *00* *ZZ*SENDER *ZZ*RECEIVER *110224*0800*^*00501*000000001*0*P*>~

Data Element Summary

Ref. Des.	Data Element	Name	Attributes
ISA01	**I01**	**Authorization Information Qualifier** Code identifying the type of information in the Authorization Information 00 No Authorization Information Present (No Meaningful Information in I02) 03 Additional Data Identification	**M 1 ID 2/2**
ISA02	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M 1 AN 10/10**
ISA03	**I03**	**Security Information Qualifier** Code identifying the type of information in the Security Information Refer to 005010X220 Data Element Dictionary for acceptable code values.	**M 1 ID 2/2**
ISA04	**I04**	**Security Information** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)	**M 1 AN 10/10**
ISA05	**I05**	**Interchange ID Qualifier** Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified This ID qualifies the Sender in ISA06. 01 Duns (Dun & Bradstreet) 14 Duns Plus Suffix 20 Health Industry Number (HIN) CODE SOURCE 121: Health Industry Number 27 Carrier Identification Number as assigned by Health Care Financing Administration (HCFA) 28 Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)	**M 1 ID 2/2**

		29	Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)			
		30	U.S. Federal Tax Identification Number			
		33	National Association of Insurance Commissioners Company Code (NAIC)			
		ZZ	Mutually Defined			
ISA06	**I06**	**Interchange Sender ID**		**M**	**1**	**AN 15/15**
		Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element				
ISA07	**I05**	**Interchange ID Qualifier**		**M**	**1**	**ID 2/2**
		Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified				
		This ID qualifies the Receiver in ISA08.				
		01	Duns (Dun & Bradstreet)			
		14	Duns Plus Suffix			
		20	Health Industry Number (HIN)			
		27	Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)			
		28	Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)			
		29	Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)			
		30	U.S. Federal Tax Identification Number			
		33	National Association of Insurance Commissioners Company Code (NAIC)			
		ZZ	Mutually Defined			
ISA08	**I07**	**Interchange Receiver ID**		**M**	**1**	**AN 15/15**
		Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them				
ISA09	**I08**	**Interchange Date**		**M**	**1**	**DT 6/6**
		Date of the interchange				
		The date format is YYMMDD.				
ISA10	**I09**	**Interchange Time**		**M**	**1**	**TM 4/4**
		Time of the interchange				
		The time format is HHMM.				
ISA11	**I65**	**Repetition Separator**		**M**	**1**	**AN 1/1**
		Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator				
ISA12	**I11**	**Interchange Control Version Number**		**M**	**1**	**ID 5/5**
		Code specifying the version number of the interchange control segments				
		00501	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003			
ISA13	**I12**	**Interchange Control Number**		**M**	**1**	**N0 9/9**
		A control number assigned by the interchange sender				
		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02. Must be a positive unsigned number and must be identical to the value in IEA02.				
ISA14	**I13**	**Acknowledgment Requested**		**M**	**1**	**ID 1/1**

Code indicating sender's request for an interchange acknowledgment

See Section B.1.1.5.1 for interchange acknowledgment information.

Refer to 005010X220 Data Element Dictionary for acceptable code values.

ISA15 **I14** **Interchange Usage Indicator** **M** **1** **ID 1/1**

Code indicating whether data enclosed by this interchange envelope is test, production or information

P	Production Data
T	Test Data

ISA16 **I15** **Component Element Separator** **M** **1** **AN 1/1**

Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

Segment: **GS** **Functional Group Header**
Position: 0075
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:
1 GS04 is the group date.
2 GS05 is the group time.
3 The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.
Comments:
1 A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.
Notes: Example: GS*BE*SENDER CODE*RECEIVER CODE*19991231*0802*1*X*005010X220A1~

Data Element Summary

Ref. Des.	Data Element	Name	Attributes
GS01	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets This is the 2-character Functional Identifier Code assigned to each transaction set by X12. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information. BE Benefit Enrollment and Maintenance (834)	**M 1 ID 2/2**
GS02	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners Use this code to identify the unit sending the information.	**M 1 AN 2/15**
GS03	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners Use this code to identify the unit receiving the information.	**M 1 AN 2/15**
GS04	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year Use this date for the functional group creation date.	**M 1 DT 8/8**
GS05	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) Use this time for the creation time. The recommended format is HHMM.	**M 1 TM 4/8**
GS06	**28**	**Group Control Number** Assigned number originated and maintained by the sender For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.	**M 1 N0 1/9**
GS07	**455**	**Responsible Agency Code** Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480 X Accredited Standards Committee X12	**M 1 ID 1/2**
GS08	**480**	**Version / Release / Industry Identifier Code** Code indicating the version, release, subrelease, and industry identifier of the	**M 1 AN 1/12**

EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE SOURCE 881: Version / Release / Industry Identifier Code

This is the unique Version/Release/Industry Identifier Code assigned to an implementation by X12N. The specific code for a transaction set defined by this implementation guide is presented
in section 1.2, Version Information.

005010X220A1

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Segment: **ST** **Transaction Set Header**
Position: 0100
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes:
1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
2 The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.
Comments:
Notes: Example: ST*834*0001*005010X220A1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
ST01	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set 834 Benefit Enrollment and Maintenance	**M**	**1 ID 3/3**
ST02	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.	**M**	**1 AN 4/9**
ST03	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention This element must be populated with the guide identifier named in Section 1.2. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time. 005010X220A1 Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003.	>>	**1 AN 1/35**

Segment: **BGN** **Beginning Segment**
Position: 0200
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the beginning of a transaction set
Syntax Notes: **1** If BGN05 is present, then BGN04 is required.
Semantic Notes: **1** BGN02 is the transaction set reference number.
2 BGN03 is the transaction set date.
3 BGN04 is the transaction set time.
4 BGN05 is the transaction set time qualifier.
5 BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction.
Comments:
Notes: Example: BGN*00*11227*19970920*1200*ES***2~

Data Element Summary

Ref. Des.	Data Element	Name	Attributes
BGN01	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set If the original transaction has already been processed, an incoming transaction using this code may be rejected by the receiver. The rejection will be identified to the sender by telephone or other direct contact. 00 Original If the original transaction has already been processed, an incoming transaction using this code may be rejected by the receiver. The rejection will be identified to the sender by telephone or other direct contact. The "00" indicates the first time the transaction is sent. 15 Re-Submission Send the "15" when the original transmission was incorrect, has yet to be processed by the receiver, and a new corrected transmission is being sent. This transmission can then be pended by the receiver's translator for further review. 22 Information Copy Send the "22" when the original transmission was lost or not processed, and the sender is passing another transmission that is the same as the original.	**M 1 ID 2/2**
BGN02	**127**	**Transaction Set Reference Number** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier This element is the transaction set reference number assigned by the sender's application. It uniquely identifies this occurrence of the transaction for future reference.	**M 1 AN 1/50**
BGN03	**373**	**Transaction Set Creation Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year This element identifies the date that the submitter created the file.	**M 1 DT 8/8**
BGN04	**337**	**Transaction Set Creation Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	**>> 1 TM 4/8**

This element is used as a time stamp to uniquely identify the transmission.

BGN05 623 Time Zone Code **1 ID 2/2**

Code identifying the time. In accordance with International Standards Organization standard 8601, time can be specified by a + or - and an indication in hours in relation to Universal Time Coordinate (UTC) time; since + is a restricted character, + and - are substituted by P and M in the codes that follow

SITUATIONAL RULE: Required when the sender and receiver are not in the same time zone.

CODE SOURCE 94: International Organization for Standardization (Date and Time)

AD	Alaska Daylight Time
AS	Alaska Standard Time
AT	Alaska Time
CD	Central Daylight Time
CS	Central Standard Time
CT	Central Time
ED	Eastern Daylight Time
ES	Eastern Standard Time
ET	Eastern Time
GM	Greenwich Mean Time
HD	Hawaii-Aleutian Daylight Time
HS	Hawaii-Aleutian Standard Time
HT	Hawaii-Aleutian Time
MD	Mountain Daylight Time
MS	Mountain Standard Time
MT	Mountain Time
PD	Pacific Daylight Time
PS	Pacific Standard Time
PT	Pacific Time
UT	Universal Time Coordinate

BGN06 127 Original Transaction Set Reference Number **1 AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference.

BGN07 640 Transaction Type Code **X 1 ID 2/2**

BGN08 306 Action Code **>> 1 ID 1/2**

Code indicating type of action

2	Change (Update) Used to identify a transaction of additions, terminations and changes to the current enrollment.
4	Verify Used to identify a full enrollment transaction to verify that the sponsor's and payer's systems are synchronized.
RX	Replace Used to identify a full enrollment transmission to be used to identify additions, terminations and changes that need to be applied to the payer's enrollment system.

Segment: **REF** **Transaction Set Policy Number**
Position: 0300
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

Notes:
1. The definition of the Master Policy Number is determined by the issuer of the policy, the Payer/Plan Administrator. The Master Policy Number may be used to meet various business needs such as indicating the line of business under which the policy is defined.
Example: REF*38*0123456~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification 38 Master Policy Number	**M**	**1 ID 2/3**
REF02	**127**	**Master Policy Number** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**>>**	**1 AN 1/50**

Segment: **DTP** **File Effective Date**
Position: 0400
Loop:
Level: Heading
Usage: Optional
Max Use: >1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Example: DTP*007*D8*19961001~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes	
DTP01	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time 007 Effective	**M**	**1**	**ID 3/3**
DTP02	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD	**M**	**1**	**ID 2/3**
DTP03	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**1**	**AN 1/35**

Segment: **QTY** **Transaction Set Control Totals**
Position: 0600
Loop:
Level: Heading
Usage: Optional
Max Use: 3
Purpose: To specify quantity information
Syntax Notes: **1** At least one of QTY02 or QTY04 is required.
2 Only one of QTY02 or QTY04 may be present.
Semantic Notes: **1** QTY04 is used when the quantity is non-numeric.
Comments:
Notes: Example: QTY*TO*10000~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes
QTY01	**673**	**Quantity Qualifier**		**M**	**1 ID 2/2**
		Code specifying the type of quantity			
		DT	Dependent Total		
		ET	Employee Total		
		TO	Total		
QTY02	**380**	**Record Totals**		**>>**	**1 R 1/15**
		Numeric value of quantity			

Segment: **N1** **Sponsor Name**
Position: 0700
Loop: 1000A Mandatory
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: Notes:
1. This loop identifies the sponsor. See section 1.5 for the definition of Sponsor.
Example: N1*P5*SPONSOR*FI*12356799~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes
N101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual		**M**	**1 ID 2/3**
		P5	Plan Sponsor		
N102	**93**	**Plan Sponsor Name** Free-form name SITUATIONAL RULE: Required when the receiver needs the sponsor name.			**1 AN 1/60**
N103	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)		**>>**	**1 ID 1/2**
		24	Employer's Identification Number		
			The identifier is the Employer Identification Number (EIN) issued by the IRS. The EIN has been adopted as the HIPAA Standard Unique Employer Identifier.		
		FI	Federal Taxpayer's Identification Number		
N104	**67**	**Sponsor Identifier** Code identifying a party or other code		**>>**	**1 AN 2/80**

Segment: **N1** **Payer**
Position: 0700
Loop: 1000B Mandatory
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: Notes:
1. This loop identifies the payer. See section 1.5 for the definition of payer.
Example: N1*IN*INSURER_NAME*FI*953402799~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes
N101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual IN Insurer	**M**	**1**	**ID 2/3**
N102	**93**	**Insurer Name** Free-form name SITUATIONAL RULE: Required when the receiver needs the payer name.		**1**	**AN 1/60**
N103	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number	**>>**	**1**	**ID 1/2**
N104	**67**	**Insurer Identifier** Code identifying a party or other code	**>>**	**1**	**AN 2/80**

Segment: **N1** **TPA/Broker Name**
Position: 0700
Loop: 1000C Optional
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes: **1** At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments: **1** This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: Situational Rule: Required when a TPA or a Broker is involved in this enrollment. See section 1.5 for definitions. If not required by this implementation guide, do not send.
Example: N1*TV*TPA_NAME*FI*123356799~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes
N101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual BO Broker or Sales Office TV Third Party Administrator (TPA)		**M**	**1 ID 2/3**
N102	**93**	**TPA or Broker Name** Free-form name		**>>**	**1 AN 1/60**
N103	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number XV Centers for Medicare and Medicaid Services PlanID CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID		**>>**	**1 ID 1/2**
N104	**67**	**TPA or Broker Identification Code** Code identifying a party or other code		**>>**	**1 AN 2/80**

Segment: **INS** **Member Level Detail**
Position: 0100
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Optional (Must Use)
Max Use: 1
Purpose: To provide benefit information on insured entities
Syntax Notes:
1 If either INS11 or INS12 is present, then the other is required.
Semantic Notes:
1 INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent.
2 INS10 is the handicapped status indicator. A "Y" value indicates an individual is handicapped; an "N" value indicates an individual is not handicapped.
3 INS12 is the date of death.
4 INS14, INS15, and INS16 identify where the employee works.
5 INS17 is the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.).
Comments:
Notes:
Notes:
1. Subscriber information must precede dependent information in a transmission.
Example: INS*Y*18*021*28*A***FT~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
INS01	**1073**	**Member Indicator**	**M**	**1 ID 1/1**
		Code indicating a Yes or No condition or response		
		ALIAS: Subscriber Indicator		
		N No		
		Y Yes		
INS02	**1069**	**Individual Relationship Code**	**M**	**1 ID 2/2**
		Code indicating the relationship between two individuals or entities		
		The value 18 must be used for the subscriber. For dependents, this value identifies their relationship to the subscriber. For example, a daughter would be value 19.		
		01 Spouse		
		03 Father or Mother		
		04 Grandfather or Grandmother		
		05 Grandson or Granddaughter		
		06 Uncle or Aunt		
		07 Nephew or Niece		
		08 Cousin		
		09 Adopted Child		
		10 Foster Child		
		11 Son-in-law or Daughter-in-law		
		12 Brother-in-law or Sister-in-law		
		13 Mother-in-law or Father-in-law		
		14 Brother or Sister		
		15 Ward		
		16 Stepparent		
		17 Stepson or Stepdaughter		
		18 Self		
		19 Child		
		Dependent between the ages of 0 and 19; age		

				qualifications may vary depending on policy	
			23	Sponsored Dependent	
				Dependents between the ages of 19 and 26 not attending school; age qualifications may vary depending on policy	
			24	Dependent of a Minor Dependent	
				A child not legally of age who has been granted adult status	
			25	Ex-spouse	
			26	Guardian	
				An adult who is given legal responsibility for a child by the court	
			31	Court Appointed Guardian	
			38	Collateral Dependent	
				Relative related by blood or marriage who resides in the home and is dependent on the insured for a major portion of their support	
				Relative related by blood or marriage who resides in the home and is dependent on the insured for a major portion of their support.	
			53	Life Partner	
				This is a partner that acts like a spouse without a legal marriage committment.	
			60	Annuitant	
			D2	Trustee	
			G8	Other Relationship	
			G9	Other Relative	
INS03	**875**	**Maintenance Type Code**			**>> 1 ID 3/3**
		Code identifying the specific type of item maintenance			
			001	Change	
				Use this code to indicate a change to an existing subscriber/dependent record.	
			021	Addition	
				Use this code to add a subscriber or dependent.	
			024	Cancellation or Termination	
				Use this code for cancellation, termination, or deletion of a subscriber or dependent.	
			025	Reinstatement	
				To place in force again, without the usual probationary or service period, a group contract or an individual's group insurance that for some reason has terminated	
				Use this code for reinstatement of a cancelled subscriber/dependent record.	
			030	Audit or Compare	
				Use this code when sending a full file (BGN08 = '4' or 'RX') to verify that the sponsor and payer databases are synchronized. See section 1.4.5, Update, Versus Full File Audits, Versus Full File Replacements, for additional information.	
INS04	**1203**	**Maintenance Reason Code**			**1 ID 2/3**
		Code identifying the reason for the maintenance change			
		SITUATIONAL RULE: Required when the payer needs to know the reason for the change. If not required by this implementation guide, do not send.			
			01	Divorce	
			02	Birth	
			03	Death	
			04	Retirement	

05	Adoption
06	Strike
07	Termination of Benefits
08	Termination of Employment
09	Consolidation Omnibus Budget Reconciliation Act (COBRA) A federal act that enables an insured, spouse, or dependent to continue benefits after a qualifying event which would otherwise cause them to lose their benefits
10	Consolidation Omnibus Budget Reconciliation Act (COBRA) Premium Paid
11	Surviving Spouse
14	Voluntary Withdrawal
15	Primary Care Provider (PCP) Change
16	Quit
17	Fired
18	Suspended
20	Active
21	Disability A physical or mental condition that makes an insured incapable of performing one or more duties of his or her own occupation
22	Plan Change Use this code when a member changes from one Plan to a different Plan. This is not intended to identify changes to a Plan.
25	Change in Identifying Data Elements A change has been made to the primary elements that identify a specific person; such elements are first name, last name, social security number, date of birth, and identification number Use this code when a change has been made to the primary elements that identify a member. Such primary elements include the following: first name, last name, Social Security Number, date of birth, and employee identification number.
26	Declined Coverage Use this code when a member declined a previously active coverage.
27	Pre-Enrollment Use this code to enroll newborns prior to receiving the newborn's application.
28	Initial Enrollment Use this code the first time the member selected coverage with the Plan Sponsor.
29	Benefit Selection Use this code when a member changes benefits within a Plan.
31	Legal Separation
32	Marriage
33	Personnel Data General information about the participant Use this code for any data change that is not included in any of the other allowed codes. An example would be change in Coordination of Benefits information.
37	Leave of Absence with Benefits

38	Leave of Absence without Benefits
39	Lay Off with Benefits
40	Lay Off without Benefits
41	Re-enrollment
43	Change of Location
	Use this code to indicate a change of address.
59	Non Payment
AA	Dissatisfaction with Office Staff
AB	Dissatisfaction with Medical Care/Services Rendered
AC	Inconvenient Office Location
AD	Dissatisfaction with Office Hours
AE	Unable to Schedule Appointments in a Timely Manner
AF	Dissatisfaction with Physician's Referral Policy
AG	Less Respect and Attention Time Given than to Other Patients
AH	Patient Moved to a New Location
AI	No Reason Given
AJ	Appointment Times not Met in a Timely Manner
AL	Algorithm Assigned Benefit Selection
EC	Member Benefit Selection
	Use this code for initial and subsequent enrollment when an insurance carrier needs to recognize that a member made an explicit plan choice.
XN	Notification Only
	Use this code in complete enrollment transmissions. This is used when INS03 is equal to 030 (Audit/Compare).
XT	Transfer
	Use this code when a member has an organizational change (i.e. a location change within the organization) with no change in benefits or plan.

INS05 1216 Benefit Status Code >> **1 ID 1/1**

The type of coverage under which benefits are paid

A	Active
C	Consolidated Omnibus Budget Reconciliation Act (COBRA) A federal act that enables an insured, spouse, or dependent to continue benefits after a qualifying event which would otherwise cause them to lose their benefits
S	Surviving Insured
T	Tax Equity and Fiscal Responsibility Act (TEFRA)

INS06 C052 Medicare Status Code **1**

To provide Medicare coverage and associated reason for Medicare eligibility

SITUATIONAL RULE: Required if a member is being enrolled or disenrolled in Medicare, is currently in Medicare or has terminated or changed their Medicare enrollment. If not required by this implementation guide, do not send.

INS06-1 1218 Medicare Plan Code **M ID 1/1**

Code identifying the Medicare Plan

A	Medicare Part A Portion of Medicare bill involving patient's hospital stay; hospital insurance
B	Medicare Part B Portion of Medicare bill involving charges by doctor, or

		other non hospital related services
	C	Medicare Part A and B
	D	Medicare
		Federal program to pay the medical expenses of those people who are 65 years or older, are disabled to the extent that they receive other Social Security benefits, dependents of deceased Social Security recipients under the age of 21, and chronic renal disease patients
	E	No Medicare

INS06-2 1701 Eligibility Reason Code **ID 1/1**

Code specifying reason for eligibility

SITUATIONAL RULE: Required if the reason for Medicare is provided to the sponsor by the member.

0	Age
1	Disability
2	End Stage Renal Disease (ESRD)

INS07 1219 Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying Event Code **1 ID 1/2**

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary

Required when a member is being enrolled in or is enrolled for a benefit covered by COBRA.

1 Termination of Employment
2 Reduction of work hours
3 Medicare
4 Death
5 Divorce
6 Separation
7 Ineligible Child
8 Bankruptcy of Retiree's Former Employer (26 U.S.C. 4980B(f)(3)(F))
9 Layoff
10 Leave of Absence
ZZ Mutually Defined

INS08 584 Employment Status Code **1 ID 2/2**

Code showing the general employment status of an employee/claimant

SITUATIONAL RULE: Required for subscriber. If not required by this implementation guide, do not send.

If this insurance enrollment is through a non-employment based program such as Medicare or Medicaid then this data element will contain the status of the subscriber in that program, rather than their employment status. Codes for non-employment based programs will be limited to "AC", Active and "TE", Terminated.

AC	Active
AO	Active Military - Overseas
AU	Active Military - USA
FT	Full-time
	Full time active employee
L1	Leave of Absence
PT	Part-time
	Part time Active Employee
RT	Retired
TE	Terminated

INS09	**1220**	**Student Status Code**		**1**	**ID 1/1**

Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured

SITUATIONAL RULE: Required when describing a non-spouse dependent whose age requires a qualifying condition for enrollment (e.g., being an active student). See the Plan contract for details of the age requirements for student status usage. If not required by this implementation guide, do not send.

F	Full-time
N	Not a Student
P	Part-time

INS10	**1073**	**Disabled Status Code**		**1**	**ID 1/1**

Code indicating a Yes or No condition or response

SITUATIONAL RULE: Required when the member is handicapped or to correct a previous report of handicapped status.

N	No
Y	Yes

INS11	**1250**	**Date Time Period Format Qualifier**		**1**	**ID 2/3**

Code indicating the date format, time format, or date and time format

SITUATIONAL RULE: Required when the Insured Individual Death Date is sent in INS12. If not required by this implementation guide, do not send.

D8	Date Expressed in Format CCYYMMDD

INS12	**1251**	**Member Individual Death Date**		**1**	**AN 1/35**

Expression of a date, a time, or range of dates, times or dates and times

SITUATIONAL RULE: Required if the subscriber/dependent is deceased. This is the date of death for the subscriber/dependent and does not replace the use of the termination date within the 2300 loop.

INS13	**1165**	**Confidentiality Code**		**1**	**ID 1/1**

Code indicating the access to insured information

R	Restricted Access
U	Unrestricted Access

INS14	**19**	**City Name**	**X**	**1**	**AN 2/30**
INS15	**156**	**State or Province Code**	**X**	**1**	**ID 2/2**
INS16	**26**	**Country Code**	**X**	**1**	**ID 2/3**
INS17	**1470**	**Birth Sequence Number**		**1**	**N0 1/9**

A generic number

SITUATIONAL RULE: Required when reporting family members with the same birth date if a birth sequence number is needed for proper reporting, tracking or response to benefits.

Segment: **REF** **Subscriber Identifier**
Position: 0200
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:

Notes:
1. This segment must contain a unique SUBSCRIBER identification number (SSN or other). This occurrence is identified by the 0F qualifier (REF01). This identifier is used for linking the subscriber with dependents as required under many policies. For Medicare Advantage products, Health Insurance Claim Number (HICN) must be sent in REF02.
Example: REF*0F*920399398~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification 0F Subscriber Number The assignment of the Subscriber Number is designated within the Insurance Contract.	**M**	**1 ID 2/3**
REF02	**127**	**Subscriber Identifier** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**>>**	**1 AN 1/50**

Segment: **REF** **Member Supplemental Identifier**
Position: 0200
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 13
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when sending additional identifying information on the member. If not required by this implementation guide, do not send.
Example: REF*17*920399398~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1 ID 2/3**
		Code qualifying the Reference Identification		
		17	Client Reporting Category	
			Code assigned by the client to categorize participants for reporting requirements	
			Used when further identification of a member is required under the insurance contract between the sponsor and the payer and allowed by federal and state regulations.	
		1L	Group or Policy Number	
		23	Client Number	
			To be used to pass a payer specific identifier for a member. Not to be used after the HIPAA standard National Identifier for Individuals is implemented.	
		3H	Case Number	
		4A	Personal Identification Number (PIN)	
			A number that uniquely identifies an individual	
			Use this code to transmit a password that is associated with the member's record.	
		6O	Cross Reference Number	
			Used when further identification of a member is required for reporting, indexing, or other purpose as mutually agreed upon between the sender and receiver of the transaction set.	
		ABB	Personal ID Number	
		D3	National Council for Prescription Drug Programs Pharmacy Number	
			CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number	
		DX	Department/Agency Number	
			Use when members in a coverage group are set up as different departments or divisions under the terms of the insurance policy.	
		F6	Health Insurance Claim (HIC) Number	
			A unique number assigned by the government to each person entitled to Medicare benefits	
			To enroll a member into a Medicare Plan (HMO, PPO, PDP, MAPD) this number is required.	

			P5	Position Code			
				Use this code to transmit the title of the member's employment position.			
			Q4	Prior Identifier Number			
				Use to pass the Identifier Number under which the member had previous coverage with the payer. This could be the result of a change in employment or coverage that resulted in a new ID number being assigned but left the member covered by the same payer.			
			QQ	Unit Number			
				Use when members in a coverage group are set up as different units under the terms of the insurance policy. Units may exist within another grouping such as division or department.			
			ZZ	Mutually Defined			
				Use this code to transmit the title of the member's employment position.			
REF02	**127**	**Member Supplemental Identifier**			**>>**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier					

Segment: **DTP** **Member Level Dates**
Position: 0250
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 24
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Example: DTP*356*D8*19960705~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
DTP01	374	Date/Time Qualifier	M	1 ID 3/3
		Code specifying type of date or time, or both date and time		
		286 Retirement Date on which the subscriber became retired		
		296 Initial Disability Period Return To Work		
		297 Initial Disability Period Last Day Worked		
		300 Enrollment Signature Date Date subscriber or dependent signed policy enrollment card To enroll a member into a Medicare Plan (HMO, PPO, PDP, MAPD) the enrollment signature date is required.		
		301 Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying Event Date of the qualifying event which initiated COBRA benefits		
		303 Maintenance Effective Date on which the maintenance is effective		
		336 Employment Begin Date on which the subscriber or dependent became employed		
		337 Employment End Date on which the subscriber or dependent ceased to be employed		
		338 Medicare Begin Date on which Medicare benefits went into effect		
		339 Medicare End Date on which Medicare benefits ceased to be in effect		
		340 Consolidated Omnibus Budget Reconciliation Act (COBRA) Begin Date on which COBRA benefits begin		
		341 Consolidated Omnibus Budget Reconciliation Act (COBRA) End Date on which COBRA benefits end		
		356 Eligibility Begin Date on which eligibility begins The date when a member could elect to enroll or begin benefits in any health care plan through the employer. This is not the actual begin date of coverage, which is conveyed in the DTP segment at position 2700.		
		357 Eligibility End Date on which eligibility ends		

			The eligibility end date represents the last date of coverage for which claims will be paid for the individual being terminated. For example, if a date of 02/28/2001 is passed then claims for this individual will be paid through 11:59 p.m. on 02/28/2001.			
		383	Adjusted Hire Date of rehire is adjusted to give an employee credit for prior years of service, after a break in service has occurred			
		394	Rehire Date the participant is rehired, after termination			
		473	Medicaid Begin Date patient became eligible for Medicaid benefits			
		474	Medicaid End Date patient no longer eligible for Medicaid benefits			
DTP02	**1250**	**Date Time Period Format Qualifier**		**M**	**1**	**ID 2/3**
		Code indicating the date format, time format, or date and time format				
		D8	Date Expressed in Format CCYYMMDD			
DTP03	**1251**	**Status Information Effective Date**		**M**	**1**	**AN 1/35**
		Expression of a date, a time, or range of dates, times or dates and times				

Segment: **NM1** **Member Name**
Position: 0300
Loop: 2100A Mandatory
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Example: NM1*IL*1*SMITH*JOHN*M**SR~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
NM101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual This code identifies if this is a correction to a previous enrollment or if it is a new, or update, enrollment transaction. 74 Corrected Insured Use this code if this transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in loop 2100B. IL Insured or Subscriber Use this code for enrolling a new member or updating a member with no change in identifying information. The identifying information for a member is specified under the insurance contract between the sponsor and payer.	**M**	**1 ID 2/3**
NM102	**1065**	**Entity Type Qualifier** Code qualifying the type of entity 1 Person	**M**	**1 ID 1/1**
NM103	**1035**	**Member Last Name** Individual last name or organizational name	**>>**	**1 AN 1/60**
NM104	**1036**	**Member First Name** Individual first name SITUATIONAL RULE: Required when NM102 is equal to "1" (person) and the person has a first name.		**1 AN 1/35**
NM105	**1037**	**Member Middle Name** Individual middle name or initial		**1 AN 1/25**
NM106	**1038**	**Member Prefix** Prefix to individual name		**1 AN 1/10**
NM107	**1039**	**Member Suffix** Suffix to individual name		**1 AN 1/10**
NM108	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when a value is being reported in the NM109 element. If not required by this implementation guide, do not send. 34 Social Security Number The social security number may not be used for any		**1 ID 1/2**

				Federally administered programs such as Medicare or CHAMPUS/TRICARE.	
			ZZ	Mutually Defined	
				Value is required if National Individual Identifier is mandated for use. Otherwise, one of the other listed codes may be used.	
NM109	**67**	**Member Identifier**			**1 AN 2/80**
				Code identifying a party or other code	
				SITUATIONAL RULE: Required when a Member Identifier is known and allowed under confidentiality regulations. If not required by this implementation guide, do not send.	

Segment: **PER** **Member Communications Numbers**
Position: 0400
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when enrolling subscribers, dependents with different contact information, or when changing a member's contact information and the information is provided to the sponsor for the member. If not required by this implementation guide, do not send.

Notes:
1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format
AAABBBCCCC, where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525).
Example: PER*IP**HP*8015554321~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes		
PER01	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**	
		Code identifying the major duty or responsibility of the person or group named				
		IP	Insured Party			
PER02	**93**	**Name**	**X**	**1**	**AN 1/60**	
PER03	**365**	**Communication Number Qualifier**	**>>**	**1**	**ID 2/2**	
		Code identifying the type of communication number				
		EM	Electronic Mail			
		HP	Home Phone Number			
		TE	Telephone			
		WP	Work Phone Number			
PER04	**364**	**Communication Number**	**>>**	**1**	**AN 1/256**	
		Complete communications number including country or area code when applicable				
PER05	**365**	**Communication Number Qualifier**		**1**	**ID 2/2**	
		Code identifying the type of communication number				
		SITUATIONAL RULE: Required when a value is being reported in the PER06 element. If not required by this implementation guide, do not send.				
		EM	Electronic Mail			
		HP	Home Phone Number			
		TE	Telephone			
		WP	Work Phone Number			
PER06	**364**	**Communication Number**		**1**	**AN 1/256**	
		Complete communications number including country or area code when applicable				
		SITUATIONAL RULE: Required when additional communication numbers are available. If not required by this implementation guide, do not send.				

PER07	**365**	**Communication Number Qualifier**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a value is being reported in the PER08 element. If not required by this implementation guide, do not send.

EM	Electronic Mail
HP	Home Phone Number
TE	Telephone
WP	Work Phone Number

PER08	**364**	**Communication Number**	**1**	**AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when additional communication numbers are available. If not required by this implementation guide, do not send.

Segment: **N3** **Member Residence Street Address**
Position: 0500
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when enrolling subscribers, dependents with different address information, or when changing a member's address. If not required by this implementation guide, do not send.
Example: N3*50 ORCHARD STREET~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
N301	**166**	**Member Address Line 1** Address information	**M**	**1 AN 1/55**
N302	**166**	**Member Address Line 2** Address information SITUATIONAL RULE: Required if a second address line exists.		**1 AN 1/55**

Segment: **N4** **Member City, State, ZIP Code**
Position: 0600
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.
Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes:
1. If address is non-U.S. or Canadian, then ZZ should be used in the N402.
2. If address is non-U.S. or Canadian, then 000000000 should be used in the N403.
Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
N401	**19**	**Member City Name** Free-form text for city name	>>	**1 AN 2/30**
N402	**156**	**Member State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada.		**1 ID 2/2**
N403	**116**	**Member Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes		**1 ID 3/15**
N404	**26**	**Country Code** Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.		**1 ID 2/3**
N405	**309**	**Location Qualifier** Code identifying type of location CODE SOURCE 206: Government Bill of Lading Office Code 60 Area The area code indicates that N406 will contain an out-of-area indicator for this member. CY County/Parish		**1 ID 1/2**
N406	**310**	**Location Identifier** Code which identifies a specific location		**1 AN 1/30**
N407	**1715**	**Country Subdivision Code** Code identifying the country subdivision SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has		**1 ID 1/3**

administrative subdivisions such as but not limited to states, provinces, cantons, etc.

CODE SOURCE 5: Countries, Currencies and Funds
Use the country subdivision codes from Part 2 of ISO 3166.

Segment: **DMG** **Member Demographics**
Position: 0800
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply demographic information
Syntax Notes:
1 If either DMG01 or DMG02 is present, then the other is required.
2 If either DMG10 or DMG11 is present, then the other is required.
3 If DMG11 is present, then DMG05 is required.
4 If either C05602 or C05603 is present, then the other is required.
Semantic Notes:
1 DMG02 is the date of birth.
2 DMG07 is the country of citizenship.
3 DMG09 is the age in years.
4 DMG11 is used to specify how the information in DMG05, including repeats of C056, was collected.
Comments:
Notes: Situational Rule: Required when enrolling a new member, changing a member's demographic information, or terminating a member. If not required by this implementation guide, do not send.
Example: DMG*D8*19450915*F*M~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
DMG01	**1250**	**Date Time Period Format Qualifier**	>>	**1 ID 2/3**
		Code indicating the date format, time format, or date and time format		
		D8	Date Expressed in Format CCYYMMDD	
DMG02	**1251**	**Member Birth Date**	>>	**1 AN 1/35**
		Expression of a date, a time, or range of dates, times or dates and times		
DMG03	**1068**	**Gender Code**	>>	**1 ID 1/1**
		Code indicating the sex of the individual		
		F	Female	
		M	Male	
DMG04	**1067**	**Marital Status Code**		**1 ID 1/1**
		Code defining the marital status of a person		
		SITUATIONAL RULE: Required when such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. This element is NOT USED when the member identified in the related INS segment is not the subscriber. If not required by this implementation guide, do not send.		
		B	Registered Domestic Partner	
		D	Divorced	
		I	Single	
		M	Married	
		R	Unreported	
		S	Separated	
		U	Unmarried (Single or Divorced or Widowed)	
			This code should be used if the previous status is unknown.	
		W	Widowed	
		X	Legally Separated	
DMG05	**C056**	**Composite Race or Ethnicity Information**		**10**
		To send general and detailed information on race or ethnicity		
		SITUATIONAL RULE: Required when such transmission is required under the insurance contract between the sponsor and payer and allowed by federal		

and state regulations. If not required by this implementation guide, do not send.

Race or Ethnicity information is reported in either DMG05-1 or DMG05-2 and DMG05-3.

DMG05-1 1109 Race or Ethnicity Code **ID 1/1**

Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes

SITUATIONAL RULE: Required when reporting the Race or Ethnicity code from the DMG05-1 list of code values. If not required by this implementation guide, do not send.

7	Not Provided
8	Not Applicable
A	Asian or Pacific Islander
B	Black
C	Caucasian
D	Subcontinent Asian American
E	Other Race or Ethnicity
F	Asian Pacific American
G	Native American
H	Hispanic
I	American Indian or Alaskan Native
J	Native Hawaiian
N	Black (Non-Hispanic) A person having origins in any of the black racial groups of Africa who is not of Mexican, Puerto Rican, Cuban, or South or Central American origin or of any other Spanish culture or origin regardless of race
O	White (Non-Hispanic) A person having origins in any of the original peoples of Europe, North Africa, or the Middle East who is not of Mexican, Puerto Rican, Cuban, or South or Central American origin or of any other Spanish culture or origin regardless of race
P	Pacific Islander
Z	Mutually Defined

DMG05-2 1270 Code List Qualifier Code **ID 1/3**

Code identifying a specific industry code list

SITUATIONAL RULE: Required when the Classification of Race or Ethnicity code set is being used to report Race or Ethnicity data. If not required by this implementation guide, do not send.

RET	Classification of Race or Ethnicity CODE SOURCE 859: Classification of Race or Ethnicity

DMG05-3 1271 Race or Ethnicity Code **AN 1/30**

Code indicating a code from a specific industry code list

SITUATIONAL RULE: Required when reporting the Race or Ethnicity code obtained from the Classification of Race or Ethnicity code. If not required by this implementation guide, do not send.

CODE SOURCE 859: Classification of Race or Ethnicity

DMG06 1066 Citizenship Status Code **1 ID 1/2**

Code indicating citizenship status

SITUATIONAL RULE: Required when such transmission is required under

the insurance contract between the sponsor and payer and allowed by federal and state regulations. This element is NOT USED when the member identified in the related INS segment is not the
subscriber. If not required by this implementation guide, do not send.

1	U.S. Citizen
2	Non-Resident Alien
3	Resident Alien
4	Illegal Alien
5	Alien
6	U.S. Citizen - Non-Resident
7	U.S. Citizen - Resident

DMG07	**26**	**Country Code**	**X**	**1**	**ID**	**2/3**
DMG08	**659**	**Basis of Verification Code**	**X**	**1**	**ID**	**1/2**
DMG09	**380**	**Quantity**	**X**	**1**	**R**	**1/15**
DMG10	**1270**	**Code List Qualifier Code**		**1**	**ID**	**1/3**

Code identifying a specific industry code list

SITUATIONAL RULE: Required when such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. If not required by this implementation guide, do not send.

REC	Race or Ethnicity Collection Code
	CODE SOURCE 860: Race or Ethnicity Collection Code

DMG11	**1271**	**Race or Ethnicity Collection Code**	**1**	**AN**	**1/30**

Code indicating a code from a specific industry code list

SITUATIONAL RULE: Required when there is a need to specify how the information in DMG05, including any repeats, was collected. If not required by this implementation guide, do not send.

Segment: **EC** **Employment Class**
Position: 1000
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: >1
Purpose: To provide class of employment information
Syntax Notes:
Semantic Notes: **1** EC04 is percent of ownership.
2 EC05 applies to the entire segment.
Comments:
Notes: Situational Rule: Required when sending additional employment class information on the member. If not required by this implementation guide, do not send.
Example: EC*04*06*07~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
EC01	**1176**	**Employment Class Code** Code indicating category of employee 01 Union 02 Non-Union 03 Executive 04 Non-Executive 05 Management 06 Non-Management 07 Hourly 08 Salaried 09 Administrative 10 Non-Administrative 11 Exempt 12 Non-Exempt 17 Highly Compensated 18 Key-Employee 19 Bargaining 20 Non-Bargaining 21 Owner 22 President 23 Vice President	>>	**1 ID 2/3**
EC02	**1176**	**Employment Class Code** Code indicating category of employee SITUATIONAL RULE: Required if further classification information is needed. If not required by this implementation guide, do not send. 01 Union 02 Non-Union 03 Executive 04 Non-Executive 05 Management 06 Non-Management 07 Hourly 08 Salaried 09 Administrative 10 Non-Administrative		**1 ID 2/3**

11	Exempt
12	Non-Exempt
17	Highly Compensated
18	Key-Employee
19	Bargaining
20	Non-Bargaining
21	Owner
22	President
23	Vice President

EC03 1176 Employment Class Code **1 ID 2/3**

Code indicating category of employee

SITUATIONAL RULE: Required if further classification information is needed. If not required by this implementation guide, do not send.

01	Union
02	Non-Union
03	Executive
04	Non-Executive
05	Management
06	Non-Management
07	Hourly
08	Salaried
09	Administrative
10	Non-Administrative
11	Exempt
12	Non-Exempt
17	Highly Compensated
18	Key-Employee
19	Bargaining
20	Non-Bargaining
21	Owner
22	President
23	Vice President

Segment: **ICM** **Member Income**
Position: 1100
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information to determine benefit eligibility, deductibles, and retirement and investment contributions
Syntax Notes:
Semantic Notes:
1 ICM01 is the frequency at which an individual's wages are paid.
2 ICM02 is the yearly wages amount.
3 ICM03 is the weekly hours.
4 ICM04 is the employer location qualifier such as a department number.
Comments:

Report $25500.25 earnings as 25500
Example: ICM*1*425*25*04011~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes	
ICM01	**594**	**Frequency Code** Code indicating frequency or type of activities or actions being reported 1 Weekly 4 Monthly 7 Annual	**M**	**1**	**ID 1/1**	
ICM02	**782**	**Wage Amount** Monetary amount	**M**	**1**	**R 1/18**	
ICM03	**380**	**Work Hours** Numeric value of quantity		**1**	**R 1/15**	
ICM04	**310**	**Location Identifier** Code which identifies a specific location		**1**	**AN 1/30**	
ICM05	**1214**	**Salary Grade Code** The salary grade code assigned by the employer		**1**	**AN 1/5**	

Segment: **AMT** **Member Policy Amounts**
Position: 1200
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: 7
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: This AMT segment is specific to family co-insurance, deductible, and premium amounts.
AMT*D2*1000~
Example: AMT*D2*100~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
AMT01	**522**	**Amount Qualifier Code**	**M**	**1 ID 1/3**
		Code to qualify amount		
		B9	Co-insurance - Actual	
			Calculated value still to be paid by the individual under the co-insurance provisions of the benefit contract This will contain any co-insurance selection amount. The option of adjusting this amount to produce the actual co-insurance can be defined in the insurance contract.	
		C1	Co-Payment Amount	
			Partial payment of medical services' expenses required in group health insurance, in addition to the membership fee; for example, for each visit to a physician a member may be required to pay $5, regardless of the expense of the services rendered; or for each prescription for drugs and medicines, the member may have to pay a flat fee of $2 regardless of the actual cost	
		D2	Deductible Amount	
			The amount of covered expenses that must be incurred by the insured before benefits become payable to the insurer	
		EBA	Expected Expenditure Amount	
		FK	Other Unlisted Amount	
		P3	Premium Amount	
			The periodic payment required to keep a policy in force	
		R	Spend Down	
			Amount that the recipient is applying towards the amount the recipient is responsible for paying each month prior to being eligible for Medicaid services	
AMT02	**782**	**Contract Amount**	**M**	**1 R 1/18**
		Monetary amount		

Segment: **LUI** **Member Language**
Position: 1500
Loop: 2100A Mandatory
Level: Detail
Usage: Optional
Max Use: >1
Purpose: To specify language, type of usage, and proficiency or fluency
Syntax Notes:
1 If either LUI01 or LUI02 is present, then the other is required.
2 If LUI04 is present, then at least one of LUI02 or LUI03 is required.
Semantic Notes:
1 LUI02 is the language code.
2 LUI03 is the name of the language.
Comments:
Notes: Situational Rule: Required if the sponsor knows that the member's primary language is not English, and such transmission is required under the insurance contract between the sponsor and payer and allowed by federal and state regulations. If not required by this implementation guide do not send.
Example: LUI*LD*123**8~

Data Element Summary

Ref. Des.	Data Element	Name	Attributes
LUI01	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when a value is being reported in the LUI02 element. If not required by this implementation guide, do not send. LE ISO 639 Language Codes CODE SOURCE 102: Languages	**1 ID 1/2**
LUI02	**67**	**Identification Code** Code identifying a party or other code ENG - English SPA - Spanish	**1 AN 2/80**
LUI03	**352**	**Description** A free-form description to clarify the related data elements and their content SITUATIONAL RULE: Required if the sender is unable to code the necessary language identification in LUI01 and LUI02. Example of communication disability: LUI***Y AUDIO~	**1 AN 1/80**
LUI04	**1303**	**Use of Language Indicator** Code indicating the use of a language SITUATIONAL RULE: Required if supplied by member. If not required by this implementation guide, do not send. 5 Language Reading 6 Language Writing 7 Language Speaking 8 Native Language	**1 ID 1/2**

Segment: **NM1** **Member Mailing Address**
Position: 0300
Loop: 2100C Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the member mailing address is different from the residence address sent in loop 2100A or when the dependent's address is different from the subscriber. If not required by this implementation guide, do not send.
Example: NM1*31*1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
NM101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M**	**1 ID 2/3**
		31 Postal Mailing Address		
NM102	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**1 ID 1/1**
		1 Person		

Segment: **N3** **Member Mail Street Address**
Position: 0500
Loop: 2100C Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: Example: N3*P.O. Box 1234~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
N301	**166**	**Mailing Address Line 1** Address information	**M**	**1 AN 1/55**
N302	**166**	**Mailing Address Line 2** Address information SITUATIONAL RULE: Required if a second address line exists.		**1 AN 1/55**

Segment: **N4** **Member Mail City, State, ZIP Code**
Position: 0600
Loop: 2100C Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.
Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes: Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
N401	**19**	**Mailing City Name** Free-form text for city name	>>	**1 AN 2/30**
N402	**156**	**Mailing State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada.		**1 ID 2/2**
N403	**116**	**Mailing Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404.		**1 ID 3/15**
N404	**26**	**Country Code** Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.		**1 ID 2/3**
N405	**309**	**Location Qualifier**	**X**	**1 ID 1/2**
N406	**310**	**Location Identifier**	**X**	**1 AN 1/30**
N407	**1715**	**Country Subdivision Code** Code identifying the country subdivision SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.		**1 ID 1/3**

Segment: **DSB** **Disability Information**
Position: 2000
Loop: 2200 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply disability information
Syntax Notes:
1 If either DSB07 or DSB08 is present, then the other is required.
Semantic Notes:
1 DSB02 is scheduled work days before the disability.
2 DSB06 is the maximum amount of disability coverage to which the insured is entitled.
3 DSB08 is the functional status code for the disability.
Comments:
Notes: Situational Rule: Required when enrolling a disabled member or when disability information about an existing member is added or changed. If not required by this implementation guide, do not send.
Example: DSB*2******DX*585~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
DSB01	**1146**	**Disability Type Code** Code identifying the disability status of the individual 1 Short Term Disability 2 Long Term Disability 3 Permanent or Total Disability 4 No Disability	**M**	**1 ID 1/1**
DSB02	**380**	**Quantity**	**X**	**1 R 1/15**
DSB03	**1149**	**Occupation Code**	**X**	**1 ID 4/6**
DSB04	**1154**	**Work Intensity Code**	**X**	**1 ID 1/1**
DSB05	**1161**	**Product Option Code**	**X**	**1 ID 1/2**
DSB06	**782**	**Monetary Amount**	**X**	**1 R 1/18**
DSB07	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) SITUATIONAL RULE: Required when a value is being reported in the DSB08 element. If not required by this implementation guide, do not send. DX International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Diagnosis The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II (diagnoses) and III (procedures), describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases and procedures; this is a diagnosis code CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) ZZ Mutually Defined To be used for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) - Diagnosis. CODE SOURCE: 897 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)		**1 ID 2/2**

DSB08	**1137**	**Diagnosis Code**	**1 AN 1/15**

Code value for describing a medical condition or procedure

SITUATIONAL RULE: Required when called for in the insurance contract between the sponsor and payer and allowed by federal and state regulations. If not required by this implementation guide, do not send.

Segment: **DTP** **Disability Eligibility Dates**
Position: 2100
Loop: 2200 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Situational Rule: Required when enrolling a disabled member or when disability dates change for an existing member, and the disability dates are known by the sponsor. If not required by this implementation guide, do not send.

Notes:
1. This segment is used to send the first and last date of disability.
Example: DTP*360*D8*19961001~

Data Element Summary

Ref. Des.	Data Element	Name			Attributes	
DTP01	**374**	**Date/Time Qualifier**		**M**	**1**	**ID 3/3**
		Code specifying type of date or time, or both date and time				
		360	Initial Disability Period Start Date on which the disability begins			
		361	Initial Disability Period End Date on which the disability ends			
DTP02	**1250**	**Date Time Period Format Qualifier**		**M**	**1**	**ID 2/3**
		Code indicating the date format, time format, or date and time format				
		D8	Date Expressed in Format CCYYMMDD			
DTP03	**1251**	**Disability Eligibility Date(s)**		**M**	**1**	**AN 1/35**
		Expression of a date, a time, or range of dates, times or dates and times				

Segment: **HD** **Health Coverage**
Position: 2600
Loop: 2300 Optional
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To provide information on health coverage
Syntax Notes:
Semantic Notes:
1 HD06 is the number of collateral dependents for the primary insured. A collateral dependent is a relative related by blood or marriage who resides in the home and is dependent on the employee for support.
2 HD07 is the number of sponsored dependents for the primary insured. A sponsored dependent is a dependent between the ages of 19 and 25 who is not in school.
3 HD09 is a late enrollee indicator. A "Y" value indicates the insured is a late enrollee, which can result in a reduction of benefits; an "N" value indicates the insured is a regular enrollee.
4 HD11 is a prescription drug service coverage indicator. A "Y" value indicates that prescription drug service coverage applies; an "N" value indicates that prescription drug service coverage does not apply.
Comments:
Notes: Example: HD*021**HLT*001+0123456+010+00001+00100+018*FAM~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
HD01	**875**	**Maintenance Type Code**	**M**	**1 ID 3/3**
		Code identifying the specific type of item maintenance		
		Required to identify the specific type of item maintenance.		
		001 Change		
		002 Delete		
		Use this code for deleting an incorrect coverage record.		
		021 Addition		
		024 Cancellation or Termination		
		Use this code for cancelling/terminating a coverage.		
		025 Reinstatement		
		To place in force again, without the usual probationary or service period, a group contract or an individual's group insurance that for some reason has terminated		
		026 Correction		
		This code is used to correct an incorrect record.		
		030 Audit or Compare		
		032 Employee Information Not Applicable		
		Certain situations such as military duty and CHAMPUS classify the subscriber ineligible for coverage or benefits. However, dependents of the subscriber are still eligible for coverage or benefits under the subscriber. Subscriber identifying elements are needed to accurately identify dependents		
		Certain situations, such as military duty and CHAMPUS/TRICARE, classify the subscriber as ineligible for coverage or benefits. However, dependents of the subscribers are still eligible for coverage or benefits under the subscriber. Subscriber identifying elements are needed to accurately identify dependents.		
HD02	**1203**	**Maintenance Reason Code**	**X**	**1 ID 2/3**
HD03	**1205**	**Insurance Line Code**	**>>**	**1 ID 2/3**

Code identifying a group of insurance products

AG	Preventative Care/Wellness
AH	24 Hour Care
AJ	Medicare Risk
	Please use this code for all Medicare Plans (HMO, PPO, or MAPD).
AK	Mental Health
DCP	Dental Capitation
	This identifies a dental managed care organization (DMO).
DEN	Dental
EPO	Exclusive Provider Organization
	This code identifies Health Network Only plans (HNO).
FAC	Facility
HE	Hearing
HLT	Health
	Includes both hospital and professional coverage.
HMO	Health Maintenance Organization
	An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment
LTC	Long-Term Care
	A plan that provides a specified dollar benefit or more commonly a percent of expenses charged if a covered person suffers a loss of functional capacity due to an accidental injury or sickness
LTD	Long-Term Disability
	A plan that provides a source of monthly income for covered employees who are unable to work because of total disability; benefits are payable for a period of 5 to 10 years, or more commonly to the employee's normal age of retirement
MM	Major Medical
MOD	Mail Order Drug
PDG	Prescription Drug
POS	Point of Service
PPO	Preferred Provider Organization
PRA	Practitioners
STD	Short-Term Disability
	A plan that provides a source of income for covered employees who are unable to work because of disability; benefits are payable for a period of 13, 26, or 52 weeks
UR	Utilization Review
	A committee of professionals in the medical field who review cases involving extended duration of hospitalization and patterns of care in order to establish guidelines in terms of actual medical necessity; their review will also include the efficiency of institutional use, the appropriateness of admission, services ordered and provided, length of stay, and discharge practices
VIS	Vision

HD04 1204 Plan Coverage Description **1 AN 1/50**

A description or number that identifies the plan or coverage

HD05	**1207**	**Coverage Level Code**		**1**	**ID 3/3**

Code indicating the level of coverage being provided for this insured

SITUATIONAL RULE: Required when called for in the insurance contract between the sponsor and payer and allowed by federal and state regulations. If not required by this implementation guide, do not send.

See section 1.4.6, Coverage Levels and Dependents, for additional information.

CHD	Children Only
DEP	Dependents Only
E1D	Employee and One Dependent
	For this code, the dependent is a non-spouse dependent. This code is not used for identification of Employee and Spouse. See code ESP.
E2D	Employee and Two Dependents
E3D	Employee and Three Dependents
E5D	Employee and One or More Dependents
E6D	Employee and Two or More Dependents
E7D	Employee and Three or More Dependents
E8D	Employee and Four or More Dependents
E9D	Employee and Five or More Dependents
ECH	Employee and Children
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only
TWO	Two Party

HD06	**609**	**Count**	**X**	**1**	**N0 1/9**
HD07	**609**	**Count**	**X**	**1**	**N0 1/9**
HD08	**1209**	**Underwriting Decision Code**	**X**	**1**	**ID 1/1**
HD09	**1073**	**Late Enrollment Indicator**		**1**	**ID 1/1**

Code indicating a Yes or No condition or response

SITUATIONAL RULE: Required when there is a need to designate a member as a late enrollee. If not required by this implementation guide, do not send.

N	No
Y	Yes

Segment: **DTP** **Health Coverage Dates**
Position: 2700
Loop: 2300 Optional
Level: Detail
Usage: Mandatory
Max Use: 6
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Example: DTP*348*D8*19961001~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
DTP01	**374**	**Date/Time Qualifier**	**M**	**1 ID 3/3**
		Code specifying type of date or time, or both date and time		
		300 Enrollment Signature Date Date subscriber or dependent signed policy enrollment card		
		303 Maintenance Effective Date on which the maintenance is effective This is the effective date of a change where a member's coverage is not being added or removed.		
		343 Premium Paid to Date End Date for which premium is paid through		
		348 Benefit Begin Date on which the subscriber's or dependent's benefit begin This is the effective date of coverage. This code must always be sent when adding or reinstating coverage.		
		349 Benefit End Date on which the subscriber's or dependent's benefit ends The termination date represents the last date of coverage in which claims will be paid for the individual being terminated. For example, if a date of 02/28/2001 is passed then claims for this individual will be paid through 11:59 p.m. on 2/28/01.		
		543 Last Premium Paid Date		
		695 Previous Period Range of previous activity This value is only to be used when reporting Previous Coverage Months.		
DTP02	**1250**	**Date Time Period Format Qualifier**	**M**	**1 ID 2/3**
		Code indicating the date format, time format, or date and time format		
		D8 Date Expressed in Format CCYYMMDD		
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31); the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date This value is only to be used when reporting Previous Coverage Months.		

DTP03	**1251**	**Coverage Effective Date**	**M**	**1**	**AN 1/35**

Expression of a date, a time, or range of dates, times or dates and times

Segment: **AMT** **Health Coverage Policy**
Position: 2800
Loop: 2300 Optional
Level: Detail
Usage: Optional
Max Use: 9
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: This AMT segment is specific to individual co-insurance, deductible, and premium amounts.

Individual Medical Co-Insurance: $1,500.50, Report as 1500.50

Individual Deductible: $250.50, Report as 250.50
AMT*B9*250.50~
Example: AMT*C1*20~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
AMT01	**522**	**Amount Qualifier Code**	**M**	**1 ID 1/3**
		Code to qualify amount		
		B9	Co-insurance - Actual Calculated value still to be paid by the individual under the co-insurance provisions of the benefit contract This will contain any co-insurance selection amount. The option of adjusting this amount to produce the actual co-insurance can be defined in the insurance contract.	
		C1	Co-Payment Amount Partial payment of medical services' expenses required in group health insurance, in addition to the membership fee; for example, for each visit to a physician a member may be required to pay $5, regardless of the expense of the services rendered; or for each prescription for drugs and medicines, the member may have to pay a flat fee of $2 regardless of the actual cost	
		D2	Deductible Amount The amount of covered expenses that must be incurred by the insured before benefits become payable to the insurer	
		EBA	Expected Expenditure Amount	
		FK	Other Unlisted Amount	
		P3	Premium Amount The periodic payment required to keep a policy in force	
		R	Spend Down Amount that the recipient is applying towards the amount the recipient is responsible for paying each month prior to being eligible for Medicaid services	
AMT02	**782**	**Contract Amount**	**M**	**1 R 1/18**
		Monetary amount		

Segment: **REF** **Health Coverage Policy Number**
Position: 2900
Loop: 2300 Optional
Level: Detail
Usage: Optional
Max Use: 14
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Example: REF*1L*123456~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1 ID 2/3**
		Code qualifying the Reference Identification		
		17	Client Reporting Category Code assigned by the client to categorize participants for reporting requirements MEDICARE ADVANTAGE PRODUCTS ONLY: Use this code to report Election Type. E - Initial eligibility period for Part D drug related plans (PDP and MAPD) I - Initial eligibility period for Medical without Part D attached (HMO, PPO and PFFS) W - Applies "post" the initial enrollment election period for all types of coverage.	
		1L	Group or Policy Number Required when a group number that applies to this individual's participation in the coverage passed in this HD loop is required by the terms of the contract between the sponsor (sender) and payer (receiver); if not required may be sent at the sender's discretion.	
		9V	Payment Category	
		CE	Class of Contract Code	
		E8	Service Contract (Coverage) Number Number or code identifying length and terms of the coverage	
		M7	Medical Assistance Category	
		PID	Program Identification Number	
		QQ	Unit Number Prior Coverage Months This code is used in this implementation guide to indicate that the value in REF02 is the response required under the portability provisions of HIPAA.	
		RB	Rate code number	
		X9	Internal Control Number Number assigned by the managing office to provide internal processing information	
		XM	Issuer Number Assigned by the Government National Mortgage Association (GNMA) to a mortgagee that is issued a	

			mortgage loan			
		XX1	Special Program Code			
		XX2	Service Area Code			
		ZX	County Code			
		ZZ	Mutually Defined			
			This is used to identify a dependent who lives outside of the network area. If a dependent is in network, then REF segment should not be passed. (Out of Area Dependent identifier.) Y - Yes (used to positively identify out of area dependents.)			
REF02	**127**	**Member Group or Policy Number**		**>>**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				

Segment: **LX** **Provider Information**
Position: 3100
Loop: 2310 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required to provide information about the primary care or capitated physicians and pharmacies chosen by the enrollee in a managed care plan when that selection is made through the sponsor. If not required by this implementation guide, do not send.

Notes:
1. Use one iteration of the loop to identify each applicable health care service provider.

2. The primary care provider effective date is defaulted to the effective date of the product identified in the DTP segment of the 2300 loop.
Example: LX*1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
LX01	554	**Assigned Number** Number assigned for differentiation within a transaction set This is a sequential number representing the number of loops for this insured person. Begin with 1 for each insured person.	M	1 N0 1/6

Segment: **NM1** **Provider Name**
Position: 3200
Loop: 2310 Optional
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes:
Notes:
1. The National Provider ID must be passed in NM109. Until that ID is available, the Federal Taxpayer's Identification Number or another identification number that is necessary to identify the entity must be sent if available. If the identification number is not available then the Provider's Name must be passed using elements NM103 through NM107 as outlined in segment note 2.
Example: NM1*P3*1******SV*25341234567*25~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
NM101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual P3 Primary Care Provider Physician that is selected by the insured to provide medical care QN Dentist	**M**	**1 ID 2/3**
NM102	**1065**	**Entity Type Qualifier** Code qualifying the type of entity 1 Person 2 Non-Person Entity	**M**	**1 ID 1/1**
NM103	**1035**	**Provider Last or Organization Name** Individual last name or organizational name SITUATIONAL RULE: Required when NM102 is equal to '1' or '2' and the sponsor is not able to provide the standard ID in element NM109. If not required by this implementation guide, do not send.		**1 AN 1/60**
NM104	**1036**	**Provider First Name** Individual first name SITUATIONAL RULE: Required when NM102 is equal to '1' and the sponsor is not able to provide the standard ID in element NM109. If not required by this implementation guide, do not send.		**1 AN 1/35**
NM105	**1037**	**Provider Middle Name** Individual middle name or initial SITUATIONAL RULE: Required when NM102 is equal to '1' and the sponsor is not able to provide the standard ID in element NM109 and has this information. If not required by this implementation guide, do not send.		**1 AN 1/25**
NM106	**1038**	**Provider Prefix** Prefix to individual name SITUATIONAL RULE: Required when NM102 is equal to '1' and the sponsor is not able to provide the standard ID in element NM109 and has this information. If not required by this implementation guide, do not send.		**1 AN 1/10**
NM107	**1039**	**Provider Suffix** Suffix to individual name		**1 AN 1/10**

		SITUATIONAL RULE: Required when NM102 is equal to '1' and the sponsor is not able to provide the standard ID in element NM109 and has this information. If not required by this implementation guide, do not send.			
NM108	**66**	**Identification Code Qualifier**		**1**	**ID 1/2**
		Code designating the system/method of code structure used for Identification Code (67)			
		SITUATIONAL RULE: Required for providers in the United States or its territories when the provider has received an NPI. If not required by this implementation guide, do not send.			
		SV	Service Provider Number		
			This is a number assigned by the payer used to identify a provider.		
		XX	Centers for Medicare and Medicaid Services National Provider Identifier		
			CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier		
NM109	**67**	**Provider Identifier**		**1**	**AN 2/80**
		Code identifying a party or other code			
		SITUATIONAL RULE: Required for providers in the United States or its territories when the provider has received an NPI. If not required by this implementation guide, do not send.			
NM110	**706**	**Entity Relationship Code**	>>	**1**	**ID 2/2**
		Code describing entity relationship			
		This element indicates whether or not the member is an existing patient of the provider.			
		25	Established Patient		
		26	Not Established Patient		
		72	Unknown		

Segment: **COB** **Coordination of Benefits**
Position: 4000
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply information on coordination of benefits
Syntax Notes:
Semantic Notes: **1** COB02 is the policy number.
Comments:
Notes: Situational Rule: Required whenever an individual has another insurance plan with benefits
similar to those covered by the insurance product specified in the HD segment for this occurrence of Loop ID-2300. If not required by this implementation guide, do not send.
Example: COB*P*XYZ123*1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
COB01	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim P Primary S Secondary T Tertiary U Unknown	>>	**1 ID 1/1**
COB02	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		**1 AN 1/50**
COB03	**1143**	**Coordination of Benefits Code** Code identifying whether there is a coordination of benefits 1 Coordination of Benefits A method of integrating benefits payable under more than one group health insurance plan so that the insured's benefits from all sources do not exceed 100 percent of the allowable medical expenses 5 Unknown 6 No Coordination of Benefits This code is sent when it has been determined that there is no COB.	>>	**1 ID 1/1**
COB04	**1365**	**Service Type Code** Code identifying the classification of service SITUATIONAL RULE: Required when detailed COB coverage information is agreed to be exchanged. If not required by this implementation guide, do not send. 1 Medical Care 35 Dental Care 48 Hospital - Inpatient 50 Hospital - Outpatient 54 Long Term Care		**9 ID 1/2**

89	Free Standing Prescription Drug
90	Mail Order Prescription Drug
A4	Psychiatric
AG	Skilled Nursing Care
AL	Vision (Optometry)
BB	Partial Hospitalization (Psychiatric)

Segment: **REF** **Additional Coordination of Benefits Identifiers**
Position: 4050
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 4
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required if additional COB identifiers are supplied by the subscriber. If not required by this implementation guide, do not send.

Notes:
1. Use the Social Security Number until the National ID Number for individuals is available.
Example: REF*6P*AZ12345~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification 60 Account Suffix Code 6P Group Number ZZ Mutually Defined Mutually Defined, will be used in this REF01 for National Individual Identifier until a standard code is defined.	**M**	**1 ID 2/3**
REF02	**127**	**Member Group or Policy Number** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	>>	**1 AN 1/50**

Segment: **DTP** **Coordination of Benefits Eligibility Dates**
Position: 4070
Loop: 2320 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Situational Rule: Required when the submitter needs to send effective dates for coordination of benefits. If not required by this implementation guide, do not send.
Example: DTP*344*D8*19960401~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes		
DTP01	**374**	**Date/Time Qualifier**		**M**	**1**	**ID 3/3**
		Code specifying type of date or time, or both date and time				
		344	Coordination of Benefits Begin			
			Date on which Coordination of Benefits begin			
		345	Coordination of Benefits End			
			Date on which Coordination of Benefits end			
DTP02	**1250**	**Date Time Period Format Qualifier**		**M**	**1**	**ID 2/3**
		Code indicating the date format, time format, or date and time format				
		D8	Date Expressed in Format CCYYMMDD			
DTP03	**1251**	**Coordination of Benefits Date**		**M**	**1**	**AN 1/35**
		Expression of a date, a time, or range of dates, times or dates and times				

Segment: **NM1** **Coordination of Benefits Related Entity**
Position: 4100
Loop: 2330 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required to send the name of the insurance company when provided to the sponsor. If not required by this implementation guide, do not send.
Example: NM1*IN*2*ABC INSURANCE CO~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
NM101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual 36 Employer GW Group IN Insurer	**M**	**1 ID 2/3**
NM102	**1065**	**Entity Type Qualifier** Code qualifying the type of entity 2 Non-Person Entity	**M**	**1 ID 1/1**
NM103	**1035**	**Coordination of Benefits Insurer Name** Individual last name or organizational name SITUATIONAL RULE: Required to send the insurance company name if no standard identifier is available to pass in NM109.		**1 AN 1/60**
NM104	**1036**	**Name First**	**X**	**1 AN 1/35**
NM105	**1037**	**Name Middle**	**X**	**1 AN 1/25**
NM106	**1038**	**Name Prefix**	**X**	**1 AN 1/10**
NM107	**1039**	**Name Suffix**	**X**	**1 AN 1/10**
NM108	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when a value is being reported in the NM109 element. If not required by this implementation guide, do not send. FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification XV Centers for Medicare and Medicaid Services PlanID CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID		**1 ID 1/2**
NM109	**67**	**Coordination of Benefits Insurer Identification Code** Code identifying a party or other code SITUATIONAL RULE: Required when supplied by the employee to the sponsor. If not required by this implementation guide, do not send.		**1 AN 2/80**

Segment: **LS** **Additional Reporting Categories**
Position: 6880
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate that the next segment begins a loop
Syntax Notes:
Semantic Notes: **1** One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as mandatory, this segment in combination with "LE", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.
Comments: **1** See Figures Appendix for an explanation of the use of the LS and LE segments.
Notes: Situational Rule: Required when needed to provide additional reporting categories about the member. If not required by this implementation guide, do not send.
Example: LS*2000~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
LS01	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use the value 2700.	**M**	**1 AN 1/4**

Segment: **LX** **Member Reporting Categories**
Position: 6881
Loop: 2700 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when needed to provide additional reporting categories about the member. If not required by this implementation guide, do not send.
Example: LX*1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
LX01	**554**	**Assigned Number** Number assigned for differentiation within a transaction set Use this sequential non-negative integer for LX loops for this member's additional reporting categories.	**M**	**1 N0 1/6**

Segment: **N1** **Reporting Category**
Position: 6882
Loop: 2750 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes: **1** At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments: **1** This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: Situational Rule: Required to specify the name of the reporting category of the member's participating entity.
Example: N1*75*SOUTHEASTERN UNION~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
N101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual 75 Participant	**M**	**1 ID 2/3**
N102	**93**	**Member Reporting Category Name** Free-form name	**>>**	**1 AN 1/60**

Segment: **REF** **Reporting Category Reference**
Position: 6883
Loop: 2750 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required to specify the reference identifier associated with the reporting category of the member's participating entity.
Example: REF*26*442~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1 ID 2/3**
		Code qualifying the Reference Identification		
		00	Contracting District Number	
		17	Client Reporting Category Code assigned by the client to categorize participants for reporting requirements	
		18	Plan Number The unique identification number assigned for a defined contribution plan	
		19	Division Identifier	
		26	Union Number	
		3L	Branch Identifier	
		6M	Application Number	
		9V	Payment Category	
		9X	Account Category	
		GE	Geographic Number	
		LU	Location Number	
		PID	Program Identification Number	
		XX1	Special Program Code	
		XX2	Service Area Code	
		YY	Geographic Key	
		ZZ	Mutually Defined	
REF02	**127**	**Member Reporting Category Reference ID**	**>>**	**1 AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		

Segment: **DTP** **Reporting Category Date**
Position: 6884
Loop: 2750 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify any or all of a date, a time, or a time period
Syntax Notes:
Semantic Notes: **1** DTP02 is the date or time or period format that will appear in DTP03.
Comments:
Notes: Situational Rule: Required when called for in the insurance contract between the sponsor and payer. If not required by this implementation guide, do not send.

Notes:
1. Use this segment to associate a date or date range with a reporting category.
Example: DTP*007*RD8*20040101-20040531~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes		
DTP01	**374**	**Date/Time Qualifier**		**M**	**1**	**ID 3/3**
		Code specifying type of date or time, or both date and time				
		007	Effective			
DTP02	**1250**	**Date Time Period Format Qualifier**		**M**	**1**	**ID 2/3**
		Code indicating the date format, time format, or date and time format				
		D8	Date Expressed in Format CCYYMMDD			
		RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31); the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY. MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date.			
DTP03	**1251**	**Member Reporting Category Effective Date(s)**		**M**	**1**	**AN 1/35**
		Expression of a date, a time, or range of dates, times or dates and times				

Segment: **LE** **Additional Reporting Categories Loop Termination**
Position: 6885
Loop: 2000 Optional (Must Use)
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate that the loop immediately preceding this segment is complete
Syntax Notes:
Semantic Notes: **1** One loop may be nested contained within another loop, provided the inner nested loop terminates before the other loop. When specified by the standards setting body as mandatory, this segment in combination with "LS", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop beginning segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.
Comments: **1** See Figures Appendix for an explanation of the use of the LE and LS segments.
Notes: Situational Rule: Required when the LS segment in position 6880 is sent. If not required by
this implementation guide, do not send.
Example: LE*2000~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
LE01	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use the value 2700.	**M**	**1 AN 1/4**

Segment: **SE** **Transaction Set Trailer**
Position: 6900
Loop:
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Syntax Notes:
Semantic Notes:
Comments: **1** SE is the last segment of each transaction set.
Notes: Example: SE*39*0001~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
SE01	**96**	**Transaction Segment Count** Total number of segments included in a transaction set including ST and SE segments	**M**	**1 N0 1/10**
SE02	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. For example, start with the number 0001 and increment from there. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.	**M**	**1 AN 4/9**

Segment: **GE** **Functional Group Trailer**
Position: 6915
Loop:
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: **1** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.
Comments: **1** The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.
Notes: Example: GE*1*1~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
GE01	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**1 N0 1/6**
GE02	**28**	**Group Control Number** Assigned number originated and maintained by the sender	**M**	**1 N0 1/9**

Segment: **IEA** **Interchange Control Trailer**
Position: 6930
Loop:
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:
Notes: Example: IEA*1*000000905~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
IEA01	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**1 N0 1/5**
IEA02	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**1 N0 9/9**

EXHIBIT H

CENSUS AND NETWORK DATA

Census and network data will be supplied upon completion of Attachment 2, *Intent to Bid Form* and signed Attachment 3, *Confidentiality Agreement*.